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**Journeys through managing the  
unknowable: making decisions about  
dangerous patients and prisoners  
with severe personality disorder**

**Julie Trebilcock**

**PhD in Criminology**

**September 2009**

**Keele University**

## SUBMISSION OF THESIS FOR A RESEARCH DEGREE

Degree for which thesis being submitted

Title of thesis

**Journeys through managing the unknowable: making decisions about dangerous patients and prisoners with severe personality disorder**

Date of submission **14 September 2009** Original registration date **September 2005**

(Date of submission must comply with Regulation 2D)

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- (e) Where I have drawn on the work, ideas and results of others this has been appropriately acknowledged in the thesis
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# Abstract

*The management of uncertainty is inherently paradoxical,  
an effort to know the unknowable (Power, 2004:59).*

Historically we have not known how to respond to offenders with personality disorder. In many respects all we have done is contain them, but this has failed to keep a hold of our anxieties. The Dangerous and Severe Personality Disorder (DSPD) Programme and four high security hospital and prison units for men have been developed in an attempt to reduce uncertainty and to help us 'know' more. Drawing from the case records of DSPD patients and prisoners and interviews with Parole Board (PB) and Mental Health Review Tribunal (MHRT) members this thesis explores how the journeys of patients and prisoners prior to and following DSPD admission are presented to the PB and MHRT, and how DSPD may impact on PB and MHRT decision-making. DSPD patients and prisoners share many similar characteristics, but following DSPD admission, some differences in their institutional responses can be identified. While the outcomes of PB and MHRT reviews with DSPD participants are different, the reviews serve many similar purposes. The uncertainty that surrounds DSPD disrupts PB and MHRT conceptions of what a normal journey through the criminal justice and/or mental health system looks like. We are not entirely certain who DSPD patients and prisoners have been, who they are, and who they may become. We do not know the extent to which DSPD treatment will reduce risk. Nor do we know how, or whether, DSPD patients and prisoners can progress to lower security facilities. Paradoxically, what we do know about DSPD, and the precautionary logic that structures DSPD, may serve to heighten our anxieties. It is this problematic terrain for decision-making, and journeys through managing the unknowable that this thesis explores.

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# **Acknowledgements**

As I write the final section of my PhD, I am overwhelmed by the number of people I need to thank for some of the most privileged and rewarding years of my life.

First, I would like to thank my supervisors Professor Anne Worrall and Dr Evi Girling for all their advice and support during my PhD. I am particularly grateful to my lead supervisor, Anne, for her early encouragement in my application to undertake a PhD, her reassurance through the moments of doubt, and for enabling me to find my academic voice.

I am also indebted to Dr Malcolm Ramsay, Head of Research for the DSPD Programme, and Dr Tim Weaver, principal investigator of the MEMOS research team from Imperial College. Without the early trust that they both afforded me, my experience of undertaking a PhD, and the research itself would have been considerably different. Both have offered me helpful guidance and support, and helped stretch my potential. I am especially grateful to Tim for his help with achieving extra funding to extend the study.

It would be impossible to name all the individuals across the fieldwork sites that have helped me during my research. Particular thanks however must be extended to: Sheena Ebsworth and all the staff in the Mental Health Act Office at Broadmoor Hospital; Liz Paine from Broadmoor staff library; Linda Fields and all the staff in the Mental Health Act Office at Rampton Hospital; Kevin Howells from the Peaks Research Unit; Andy Brown and Steve Wright, Lifer Managers at HMP Whitemoor; Dr Mark Freestone, Louise Barfield and Annette Crooks at HMP Frankland; Alistair McMurdo and Geraldine Nolan from the Public Protection Unit, Ministry of Justice; Jack Fargher

and Liz Ralph from the MHRT Service; and Martha Blom-Cooper from the Parole Board.

I would also like to extend thanks to the IDEA research team from Oxford University, that I was privileged to work alongside. These are (in alphabetical order): Tom Burns, Martin Clarke, Wendy Dyer, Zoe Elkington, Alison Foster, Lindsey Johnston, Cara Jones, Helen McKinnon, Jacinta Prendergarst, Julia Sinclair, Lucy Willmott, and Jenny Yiend. I would like to also thank Mary Leamy from the Imperial College MEMOS research team. I am grateful for the friendship, helpful advice and support that they all extended to me during my research.

I am especially grateful to all the patients, prisoners, Parole Board and Mental Health Review Tribunal members who took part in the study. I am also thankful to a number of DSPD staff who took part in an extension to the study. Without the consent, time, and valuable insights of these individuals, my research would have been impossible. I sincerely hope that the research presented here accurately captures the experiences and challenges faced by every one of them.

I would like to thank the Economic and Social Research Council (ESRC) for funding my PhD (Award number: PTA031200400034) and the DSPD Programme for funding an extension to the study.

Finally, I would like to thank my family, friends and fellow PhD students for all their friendship and support during my PhD. Most of all, I would like to thank my mother, for inspiring and motivating me in a way that no-one else can, and for passing on just a little of her determination and passion for life. Without you mum, none of this would have been possible.

# 1. Introduction

## Background and context

On the 9<sup>th</sup> July 1996, a mother and daughter, Lin and Megan Russell, were killed in a hammer attack while walking along a country lane in Chillenden, Kent. Josie Russell, the nine year old daughter of Lin and sister to Megan survived the brutal attack but was left with severe head injuries. Understandably the tragedy provoked public outrage, which was heightened when media reports emerged that the suspected perpetrator, Michael Stone, was not only known to psychiatric services as suffering from a personality disorder, but had been refused a secure hospital bed in the weeks leading up to the attack, on the basis that he was 'untreatable' under mental health legislation<sup>1</sup>.

Following this high profile moment, and within two years of New Labour taking office in May 1997, proposals to deal with people with a 'Dangerous and Severe Personality Disorder' (hereafter DSPD) emerged. Since this time, the DSPD Programme, a joint initiative of the Ministry of Justice (previously part of the Home Office)<sup>2</sup>, Department of Health, and Her Majesty's Prison Service have opened four high security pilot services for men within two high security hospitals (Broadmoor and Rampton) and two high security prisons (HMP Whitemoor and HMP Frankland). A ten to twelve bed pilot within the prison estate to assess and treat the needs of female offenders and seventy-five medium secure and community pilot places have also been set up, alongside a research and development programme to evaluate these services.

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<sup>1</sup> Under the Mental Health Act 1983 (prior to amendments under the MHA 2007), individuals classified as suffering from psychopathic disorder (the closest legal definition to the clinical term personality disorder) could only be detained if psychiatrists believed that treatment was 'likely to alleviate or prevent deterioration of his condition' (Section 3(2)b).

<sup>2</sup> When I began my PhD the DSPD Programme was part of the Home Office, Department of Health and Her Majesty's Prison Service. Following a government reshuffle in May 2007 the Home Office was split in two. The newly created Ministry of Justice took responsibility for prisons and probation services. For more information see Faulkner and Gibson (2007) and <http://www.justice.gov.uk>.

## **Overview of study and key research questions**

The primary focus of this thesis is with the institutional journeys of male patients and prisoners prior to, and following DSPD admission, and how placement in a high security DSPD unit may affect Parole Board (hereafter PB) and Mental Health Review Tribunal (hereafter MHRT) decision-making. Theoretically the thesis draws from research that has employed the concept of a journey or career as a framework for making sense of the institutional pathways of patients and prisoners. During the study it became apparent that PB and MHRT members conceive prisoners and patients as needing to undergo a journey through the criminal justice and/or mental health system before they are suitable to be considered for release. Along these journeys, many key decision-stages exist, including PB and MHRT reviews. At each of these decision-stages, participants are 'made up' (Hacking, 1986; McCallum, 2001) and 'made sense' of by report writers and decision-makers. Based on this, the following questions were considered:

- 1) What are the characteristics of the men detained in the four high security DSPD units? What journeys have they made prior to and following DSPD admission? How do multi-disciplinary report writers present DSPD patients and prisoners (and the DSPD units) to the PB/MHRT?
- 2) What were the outcomes of PB/MHRT with DSPD participants? Does placement on a DSPD unit impact on PB/MHRT decision-making? What sense have PB/MHRT members made of DSPD?

In order to answer these questions, twelve months were spent collecting data in the four high security pilot DSPD units for men. One hundred and twelve male patients and prisoners across the four DSPD units consented to the study. Basic demographic information was collected about all of them. Further investigation revealed that since

admission to DSPD services and during the study period, thirty-five prisoners had had fifty-two PB reviews and twenty-four patients had had twenty-eight MHRT reviews. It is these male patients and prisoners with experience of a PB or MHRT following their admission to a DSPD unit that this thesis considers.

For those with experience of a PB or MHRT since admission to DSPD detailed information relating to the conduct and outcome of PBs and MHRTs was collected from the DSPD units, the Ministry of Justice, and the Mental Health Review Tribunal Service. MHRT reports, PB dossiers, DSPD reports and PB and MHRT decision letters were collected and used to generate a database with details of each participant's legal status (i.e. the date, type and length of sentence or section), the outcome of any PB/MHRT, and other key information including index offence<sup>3</sup>, location prior to DSPD admission, and parole eligibility dates.

Twenty-three semi-structured interviews were conducted with MHRT and PB members to explore how DSPD may (or may not) impact on their decision-making. Several themes were considered in the interviews including: members' experience of DSPD hearings; the significance of information; (dangerous and severe) personality disorder; dangerousness and risk assessment; treatability; engagement; and progression.

## **Rationale**

It is important to consider how patients and prisoners respond to admission to a DSPD unit, and how external decision-makers like the PB and MHRT may interpret their placement, because it is a stage at which patients and prisoners are redefined as in need of specialist personality disorder treatment. Those with psychopathy can be presented as 'evil', 'beyond psychiatric help' (Mason et al, 2006:337) and as a 'species of humans suited to isolation' (Rhodes, 2002:458). This is significant because notions

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<sup>3</sup> Index offence refers to the offence that led to the participant's current detention.

of evil can influence the planning of care (Mason et al, 2006; Mercer et al, 2000), while a diagnosis of personality disorder can help reinforce and justify high security containment as a natural and right response (Rhodes, 2002). One problem that arises from this is that it becomes difficult for anyone to take responsibility for a prisoner's release to lower security (Rhodes, 2002). In this sense, personality disorder has the potential to be a 'disastrous label' and one almost guaranteed to extend the length of detention (George, 1998:106).

As a new and relatively controversial programme, it is important to study how external decision-makers interpret the institutional journeys of prisoners and patients and their placement in a specialist DSPD unit. While research has considered how prisoners may adapt and respond to imprisonment, there is very little research that considers how, in practice, patients and prisoners travel through prison and mental health services. There is also very little research concerned with PBs and MHRTs, in comparison to other decision-making stages in the criminal justice and mental health system. This thesis contributes to these areas of research, and also adds to the small, but growing literature on the DSPD programme.

## **Overview of thesis**

*Chapter two* traces the emergence of the DSPD Programme and four high security units for men. The chapter highlights the considerable uncertainty that surrounds DSPD, and explores some of the reasons behind, and the challenges raised by, its emergence. Historically we have not known how to respond to offenders with personality disorder, and the chapter argues that they are a group whom 'nobody knows'. While DSPD is structured by risk and a concern for public protection, it also reflects an increasing investment and focus in 'knowing' and finding out 'what works' with offenders with personality disorder. This investment in 'knowing' is argued to



follow from a precautionary logic that seeks to generate certainty and prevent the possibility of a 'worst case scenario'.

*Chapter three* outlines the methodological approach to the study. The chapter traces the journey of the research and the researcher over four years. It outlines the research questions, samples and data sources for the study, and describes how the researcher was able to secure access to the four high security DSPD units for men, the PB and the MHRT. The chapter argues that research within high security settings, particularly that undertaken at doctorate level, must be flexible and opportunistic. Challenges along the research journey should be regarded as part of the business of conducting research in high security settings, and the role and response of the researcher to the field under study should be subject to reflection.

*Chapter four* outlines the theoretical framework that underpins the study. Theoretically, the thesis is structured around the notion that prisoners and patients undergo a journey while in detention, and along this journey key decision-stages exist, including PB and MHRT reviews. At these decision-stages, DSPD report writers present DSPD patients and prisoners to the PB and MHRT. The PB and MHRT must then make sense of the DSPD participants and the DSPD units. The chapter explores previous literature about how patients and prisoners experience detention in a secure institution, some of the dilemmas raised by trying to know the unknowable, and the key characteristics of decision-making.

*Chapter five*, the first data chapter of the thesis, draws from the reports supplied to the PB and MHRT at later reviews, to explore the characteristics and the institutional journeys of a sample of patients and prisoners, prior to their admission to DSPD services. It is difficult to disentangle the differences between patients and prisoners prior to their admission to DSPD services. While a range of institutional adaptations are

described by report writers, the majority of patients and prisoners are reported as disruptive prior to DSPD admission. Many patients and prisoners were also presented as a vulnerable population, and nearly all are reported as having completed an unsatisfactory amount of treatment while in detention. It is apparent that services at all stage of their lives either haven't wanted to know, or haven't known what to do with them. Similarly, the patients and prisoners themselves have often not wanted to know, or be known.

*Chapter six* continues the journey of DSPD participants, following their admission to DSPD services. Drawing from the reports submitted to the PB and MHRT the chapter explores how participants are described as having responded to the DSPD units. The reports submitted to the PB and MHRT present placement in a DSPD unit as appropriate, and in the case of patients, legal under the Mental Health Act 1983. While the backgrounds and institutional responses of prisoners and patients were identified in chapter five as relatively similar, it is of note, that following DSPD admission differences can be identified in how the two groups respond to DSPD, and consequently, how they are presented to the PB and MHRT. The chapter identifies some challenges with evidencing risk reduction, and highlights that insufficient attention is given to how patients and prisoners will be discharged from the DSPD units.

*Chapter seven* explores the significance of DSPD for PB decision-making. Drawing from all the PB outcomes for a sample of thirty-five prisoners with fifty-two reviews since admission to DSPD and interviews with PB members, the chapter explores the outcomes and different uses made of PB reviews with DSPD prisoners. No DSPD prisoner was recommended for a move to an open prison or for release to the community, and PB members argued that the high security location of DSPD services was more important for their decision-making than the label of DSPD. The chapter suggests that the short history of DSPD services, and the uncertainty that surrounds

them, raise anxieties amongst external decision-makers and disrupts previous conceptions of a normal journey through the prison system. PB members had particular concerns about how to make sense of the risk of DSPD prisoners and were unsure of the relationship of DSPD services with the wider prison estate.

*Chapter eight* then explores the significance of DSPD for MHRT decision-making. Drawing from the MHRT outcomes provided to twenty-four patients with twenty-eight reviews, and interviews with a range of MHRT members, the chapter explores a variety of MHRT outcomes, including discharge to the community, recommendation for transfer back to the prison service, recommendation for transfer to medium security, and reclassification of mental disorder. Although MHRT outcomes differed from PB outcomes with DSPD participants, the analysis identifies that the two types of review often serve similar purposes. Like PB members, MHRT members highlighted that the high security location was more important than the DSPD label for the decisions that they made. MHRT members also expressed some concerns about the futures of DSPD patients, suggesting that DSPD has the capacity to disrupt their ideas about what an appropriate journey through the mental health system should look like.

*Chapter nine* is the concluding chapter of the thesis. The thesis concludes that the DSPD units themselves are on a journey. While confidence in the DSPD Programme may develop as more becomes known, many of the future journeys of the DSPD units and the individuals whom they detain are unknowable. Paradoxically, the precautionary logic that structures DSPD and attempts to generate certainty by knowing more about DSPD, has the potential to undermine what DSPD has been set up to do. The challenge for DSPD services is to develop strategies that tolerate and build on the unknowable, rather than present it as resolvable. Some aspects of DSPD, like routes for progression, can be better known, and it is important that these are developed,

because without these, the potential for DSPD services to have a positive impact may never be fully realised.

## 2. Exploring the DSPD policy journey

*Perhaps the only thing about personality disorder on which every written authority agrees is that nobody comprehensively knows what it is (Bowers, 2002:2).*

*I don't know who these people are (Professor John Gunn  
quoted in Yamey, 1999:1322).*

### Introduction

Following the high profile Michael Stone case<sup>4</sup>, and within two years of New Labour taking office, proposals to deal with people with a 'Dangerous and Severe Personality Disorder' (hereafter DSPD) emerged. This has led to the development of four high security units for men in both the Prison Service and the mental health system. Alongside the emergence of DSPD services many other related legislative and policy shifts have been witnessed including a determined attempt to reform the Mental Health Act 1983 (hereafter MHA 1983) and the introduction of a plethora of criminal justice legislation. It is important to consider how programmes like DSPD emerge, and to this end, this chapter seeks to outline and make sense of the emergence and development of DSPD services since 1997<sup>5</sup>.

### New Labour and the emergence of DSPD

In January 1998, less than a year after New Labour took office, a government report declared that 'care in the community has failed' (Department of Health, 1998b:Foreword). The report proposed to bring mental health law up-to-date by

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<sup>4</sup> For more details regarding the Michael Stone case see the report published by the South East Coast Strategic Health Authority (2006).

<sup>5</sup> The chapter is necessarily selective but for an extended analysis of the historical response to those identified as mentally disordered, personality disordered and/or dangerous see McCallum (2001); Peay (2007); Pratt (1997); and Seddon (2007).

ensuring that patients are 'no longer allowed to refuse to comply with the treatment they need' and, significantly, that:

[w]e will also be changing the law to permit the detention of a small group of people who have not committed a crime but whose untreatable psychiatric disorder makes them dangerous ... For those people with a severe personality disorder who are considered to pose a grave risk to the public ... admission to the new regime will not be dependent upon the person having committed an offence, nor whether they are treatable under the terms of the Mental Health Act (Department of Health, 1998b:Foreword - para. 4.33).

It was evident that the government sought to close the perceived 'loop-hole' within the MHA 1983 in regard to the detention of people with personality disorder in hospital. Under the MHA 1983 (prior to amendments under the MHA 2007) individuals classified as suffering from 'psychopathic disorder', one of four legal categories of mental disorder, and the closest to the clinical term of 'personality disorder', could only be detained in hospital if treatment was 'likely to alleviate or prevent deterioration of his condition' (Section 3(2)b).

Proposing that a 'third way' was needed in mental health, the government set up an expert committee in September 1998 to review the MHA 1983 (Department of Health, 1998a). A month later, Michael Stone was convicted of the murders of Lin and Megan Russell and sentenced to life imprisonment. His conviction, in some quarters continues to be held as questionable<sup>6</sup>, but although the evidence was weak, Stone was nevertheless presented as the '*sort of person* who would have committed such crimes' (Hudson, 2001:107):

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<sup>6</sup> In 2007, after a retrial in 2001 and an unsuccessful appeal in 2005, the Criminal Cases Review Commission (CCRC) are reported to have begun a fresh search for new evidence in the case. See <http://uk.reuters.com/article/domesticNews/idUKL3041164020070930>

The reasoning is that if Stone didn't commit the Chillenden murders he has committed some other, if less serious crimes that he should be punished for, that if he hasn't he is the sort of person who would have murdered someone given time and opportunity, and if neither, well, he's only a scumbag anyway, a burden on society and a junkie at that (Earl, 2003:5).

In February 1999, before the review of the MHA 1983 was complete, Jack Straw, the then Home Secretary announced the intention of the Home Office and the Department of Health to deal with:

a group of dangerous and severe personality disordered individuals from whom the public at present are not properly protected, and who are restrained effectively neither by the criminal law nor by the provisions of the Mental Health Act (HC Deb, Vol 325, Col 601, 15 Feb 1999).

A few months later a DSPD consultation document emerged, explaining that DSPD was a working definition that referred to individuals over the age of eighteen 'who have an identifiable personality disorder to a severe degree, who pose a high risk to other people because of their serious anti-social behaviour resulting from their disorder' (Home Office and Department of Health, 1999:12). In all, 2,400 people were considered to meet the criteria for DSPD: 1,400 of these were likely to be in prison; 400 in secure hospitals; and the remainder, of up to 600 in the community (Home Office and Department of Health, 1999:12). Ninety-eight percent of people meeting the DSPD criteria would be men.

The document centred around two sets of proposals to deal with the risk posed by those with DSPD. The first proposal (Option A), suggested amending existing mental health and criminal legislation so that individuals diagnosed with personality disorder

still considered a risk to the public would not be released. The second proposal (Option B) suggested developing a new legal and service framework which would introduce indeterminate sentences for those diagnosed with DSPD. The document further explained:

At present individuals in this group may, broadly speaking be detained in prison as punishment following conviction for an act they have committed, or in hospital to receive treatment designed to bring about an improvement in diagnosed mental disorder. The approach the Government has developed to managing dangerous severely personality disordered people involves the idea of detention based on the serious risk such people present to the public (Home Office and Department of Health, 1999:9).

It was apparent that this was a problem that needed urgent remedy, as the document noted that 'decisions on the direction of policy development for managing this group cannot be delayed until the outcomes of the research are known' (Home Office and Department of Health, 1999:3). Although further encouragement was probably unnecessary, the publication of the Fallon Report (Fallon et al, 1999) following an inquiry into a specialist personality disorder ward at Ashworth High Security Hospital<sup>7</sup> in January 1999, and the release of Noel Ruddle from secure psychiatric care in Scotland on the grounds of untreatability<sup>8</sup> in August 1999, are likely to have reinforced the government's determination to tackle the issues presented by DSPD.

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<sup>7</sup> This inquiry was commissioned following a former patient's allegations of the misuse of drugs and alcohol, the running of businesses, availability of pornography and paedophile activity on the unit. The inquiry largely confirmed the allegations, and most worryingly, confirmed that a child was being groomed by patients on the unit. The report recommended the closure of the unit and the introduction of reviewable indeterminate sentences for those with severe personality disorders.

<sup>8</sup> On the 2<sup>nd</sup> August 1999 Noel Ruddle, a convicted murderer still assessed to present a danger to the public, was released from psychiatric care as his continued detention was judged to be unjustifiable on the basis of him being untreatable (*Ruddle v. Secretary of State for Scotland* (1999)). In response the *Mental Health (Public Safety and Appeals) (Scotland) Act 1999* introduced public safety to the grounds for not discharging patients.



In November 1999, the Richardson *Review of the Mental Health Act 1983* (Department of Health, 1999b) and the Green Paper *Reform of the Mental Health Act: Proposals for Consultation* (Department of Health, 1999a) were published. Much concern surrounded the dissonance between the two documents (Bowen, 2000; Peay, 2000; Szmukler and Holloway, 2000; Zigmond and Holland, 2000). While the Richardson Committee favoured MHA reform on the basis of principles of non-discrimination, patient autonomy, and capacity, the Green Paper rejected the central tenets of the report. The Richardson Committee's concern with 'capacity' was seen as 'largely irrelevant' and dropped in favour of risk (Peay, 2003:148-9):

Where Richardson was urged to be radical, the Green Paper's conception of modernising mental health services entailed a controlling and cautionary emphasis; its vision was retrograde (Peay, 2003:148).

The following year, the Home Affairs Committee (2000) published their *First Report: Managing Dangerous People with Severe Personality Disorder*. A week later on 14<sup>th</sup> March 2000 a Dangerous People with Severe Personality Disorder Bill was presented to the House of Commons. This proposed to introduce DSPD Orders for individuals 'suffering from a severe personality disorder' found to be 'presenting a danger to the public as a result of the disorder' (Section 1a-b). Those detained under a DSPD order would be held in facilities which provide 'a reasonable level of security for the public from the person detained' for the management and treatment of their disorder (Section 4(1)a-b). Significantly, the Bill noted:

[f]or the avoidance of doubt it is hereby declared that it is not a condition for the imposition of a DSPD Order that such treatment is likely to alleviate or prevent a deterioration in the person's condition (Section4(1)b).

Later in 2000, the government responded to the Home Affairs Committee, and noted that of those who had expressed a preference between Options A and B during the consultation process, the majority had preferred Option B, that is, the development of separate DSPD legislation (Home Office, Prison Service and Department of Health, 2000). It was identified that this preference was accompanied by concerns about detention in civil cases and the lack of consensus and consistency in the diagnosis of personality disorder and assessments of dangerousness. The document noted that because:

of the strong links between these proposals and wider changes to the Mental Health Act, the Government will want to ensure that these two sets of changes are developed in parallel (Home Office, Prison Service and Department of Health, 2000:4).

In December 2000, a White Paper to reform the MHA 1983 was published in two parts (Department of Health, 2000a, 2000b). With a whole part dedicated to 'high risk patients' (Department of Health, 2000b) it was apparent that risk was high on the agenda and that mental health law was moving closer towards penal law. The paper proposed to remove the categories of mental disorder in the MHA 1983 in favour of a broad definition so that 'no particular clinical diagnosis will have the effect of limiting the way that the powers are used' and to 'move away from the narrow concept of "treatability"' (Department of Health, 2000a:22). The proposed broad definition of 'mental disorder' and removal of the 'treatability test' raised concerns about how widely the new legislation could be applied. While the White Paper further outlined Options A and B, the paper explained that legislative changes in relation to DSPD alone were not enough, and needed to be backed up by a programme of service development. To this end, the paper outlined that £126 million had been allocated to the Home Office, Prison

Service and Department of Health for the development of specialist DSPD services over the next three years:

The Government has decided that before taking final decisions on how best to provide services for this group in the long term, it needs to pilot and evaluate the assessment process and the various treatments available for this group within existing service structures (Department of Health, 2000b:11).

By the following year, DSPD was no longer an idea, it had become a practice. The first DSPD site to open was the Fens Unit, which opened within an existing wing of HMP Whitemoor in early 2001. The second prison based DSPD site, the Westgate Unit at HMP Frankland opened in March 2004. Both units were originally commissioned to provide eighty-four and eighty beds respectively, although it is now proposed that the Fens Unit will now provide seventy beds while the Westgate unit will offer eighty-six. The first DSPD unit in the mental health system opened as a ten bed pilot ward in April 2003 on Bicester ward, at Broadmoor Hospital, until the formal DSPD unit, the Paddock Unit opened in October 2005. The other hospital based DSPD unit, The Peaks, opened at Rampton Hospital in March 2004. Both hospital units were originally commissioned to have seventy beds each, although their capacity has now been limited to forty-six and sixty respectively.

Substantial funding was devoted to the DSPD Programme and the development of the high secure DSPD units. Three of the four high security units for men were newly built. Barrett and Byford (2007:s75) argue that although clinical and public protection outcomes are important, it is crucial that the programme can also be justified in terms of its cost-effectiveness. The costs involved are difficult to calculate, but unsurprisingly, they are high. A Freedom of Information (FOI) request in 2005 established that the

average cost of a DSPD bed was £111,000 at HMP Whitemoor, £113,000 at HMP Frankland, £210,000 at Broadmoor and £213,000 at Rampton<sup>9</sup>.

Host institution	Unit	Opened	Original capacity	Current capacity
Broadmoor Hospital	Paddock Unit	Oct 2005	70	46
Rampton Hospital	Peaks Unit	Mar 2004	70	60
HMP Whitemoor	Fens Unit	2001	84	70
HMP Frankland	Westgate Unit	May 2004	80	86
<b>Total beds</b>			304	262

**Table 1: Capacity of the DSPD high secure services for men**

The four high security DSPD units for men are overseen by Planning and Delivery Guidance (2005a; 2008b). The delivery guidance explains that the DSPD programme is keen to ensure that ‘treatment services are structured and focused around facilitating progression through reducing risk’ (DSPD Programme, 2005a:8). The target outcomes of the DSPD high secure services are stated as:

- 1) improved public protection
- 2) provision of new treatment services improving mental health outcomes and reducing risk, and
- 3) better understanding of what works in the treatment and management of those who meet the DSPD criteria (DSPD Programme, 2005a:6).

<sup>9</sup> For the results of several detailed economic evaluations of DSPD see Barrett and Byford (2007); Barrett et al (2005); and Barrett et al (2009).

Although many of the early admissions to DSPD services were ‘voluntary’, in contrast to the admissions policies of Grendon Underwood<sup>10</sup>, an individual does not have to be in agreement for a referral or admission to DSPD services to be made. A man can be admitted to one of the four high security DSPD units for men, if assessment identifies that:

- 1) He is more likely than not to commit an offence that might be expected to lead to serious physical or psychological harm from which the victim would find it difficult or impossible to recover, and,
- 2) He has a severe disorder of personality<sup>11</sup>, and
- 3) There is a link between the disorder and the risk of reoffending (DSPD Programme, 2005:8).

The admission criteria for the four high security units is the same, although admissions to the hospital units must also meet the criteria of the Mental Health Act 1983. On this basis, the DSPD Programme (2005a:10) expect that ‘each of the units will be taking similar groups of people’. That the admission criteria is the same for the hospital and prison based units raises some important questions about who the units are intended to cater for. The DSPD guidance reveals that it is more appropriate to refer individuals to the hospital based units if:

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<sup>10</sup> HMP Grendon Underwood was opened in 1962 as an experimental psychiatric prison to provide treatment for prisoners with antisocial personality disorders. It has six wings that provide 235 places for Category B and C prisoners. It is run along the lines of a democratic therapeutic community, and has been accredited by the Correctional Services Accreditation Panel (CSAP).

<sup>11</sup> Defined as either: a Psychopathy Checklist-Revised (PCL-(R)) score of 30 or above (or the Psychopathy Checklist-Shortened Version (PCL-SV) equivalent); or a PCL-(R) score of 25-29 (or the PCL-SV equivalent) plus at least one personality disorder diagnosis from the American Psychiatric Association’s *Diagnostic and Statistical Manual of Disorders* Edition IV (DSM-IV) other than anti-social personality disorder; or two or more DSM-IV personality disorder diagnoses (DSPD Programme, 2008b:14-15). See Appendix E for more information.

- the individual has mental health treatment needs that can be best met in a hospital environment
- an individual is near the end of their sentence and is likely to require continued detention under mental health legislation in order to complete treatment (DSPD Programme, 2005a:10).

A number of assessment tools to be used in the pilot units are identified by the DSPD guidance (2005a), including: the Violence-Risk Scale (VRS)<sup>12</sup> and Historic-Clinical-Risk Scale (HCR-20)<sup>13</sup> to assess the risk of violence; the Risk Matrix 2000<sup>14</sup>, Static 99<sup>15</sup> and the Structured Assessment of Risk and Need (SARN)<sup>16</sup> to assess the risk of sexual offending; the Structured Clinical Interview for the DSM-IV-TR (SCID-1) to assess the presence of mental illness; and finally, the Psychopathy Checklist-Revised (PCL-R)<sup>17</sup>, Psychopathy Checklist-Shortened Version (PCL-SV) and the International Personality Disorder Examination (IPDE) to assess the presence of personality disorder (DSPD Programme, 2005)<sup>18</sup>.

Treatment on a DSPD unit is delivered by multi-disciplinary teams. The treatment models used in each of the DSPD units have been defined and developed locally, and as a result the treatment models differ considerably across the four high secure units for men. Little information is provided by the DSPD Planning and Delivery Guidance (2005a, 2008b) about treatment models, but further information about the pilot clinical models is provided in Appendix E.

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<sup>12</sup> See Wong and Gordon (2001) for more information.

<sup>13</sup> See Webster et al (1997) for more information.

<sup>14</sup> See Thornton et al (2003) for more information.

<sup>15</sup> See Hanson and Thornton (1999) for more information.

<sup>16</sup> See Webster et al (2006) for more information.

<sup>17</sup> See Hare (1991) for more information.

<sup>18</sup> See Appendix E and Dolan and Doyle (2000) for further discussion about these assessment tools.

Although women have been largely neglected in discussions about DSPD, the Primrose project, a ten to twelve bed pilot, has been developed at HMP Low Newton (DSPD Programme, 2006). This pilot unit for women differs from the high secure units for men, because it is integrated with the prison wing in which it is based. While there is a separate area for therapy, in contrast to male DSPD prisoners, residents of the Primrose project are not separated from other prisoners in terms of residence, recreation or rules (ibid).

<b>Trust</b>	<b>MSU capacity</b>	<b>Community capacity</b>
Northumberland, Tyne and Wear NHS Trust	16 permanent beds from Feb 2006	Community team and access to hostel beds – from November 2003
South London and Maudsley Mental Health NHS Trust	16 permanent beds from autumn 2006	Community team and specialist PD hostel from Oct 2004
East London and the City Mental Health NHS Trust	20 permanent in-patient beds from December 2005	Community team and specialist PD supported housing from Dec 2004
Oxleas Mental Health NHS Trust	-	6 Specialist PD hostel and outreach team from June 2004
Merseyside Probation Service (NOMS) and Mersey Care Mental Health NHS Trust	-	30 place Community Risk Assessment and Case Management Service (CRACMS). Now Resettle

**Table 2: Capacity of the medium secure and community DSPD pilots**

Seventy-five medium secure and community DSPD pilot places have also been developed by the DSPD programme (DSPD Programme, 2005b, 2008a; see Table 2 and Haigh, 2007a, 2007b for more information). This includes several medium secure

units, and Resettle (formerly CRACMS), a multi-agency community based project in Merseyside for offenders released from prison with personality disorder. When one considers that the current capacity of high secure DSPD services for men and women is 274, it is clear that the DSPD medium secure and community pilots are in short supply. Those who fall outside of the National Health Service (NHS) and National Offender Management Service (NOMS) catchment areas for medium secure and community services are likely to be at a particular disadvantage.

HMP Grendon, a Category B prison and accredited democratic therapeutic community, has been identified as a progression site for DSPD prisoners<sup>19</sup>. The aim of the progression service at HMP Grendon is to take men who have completed treatment in one of the high secure prison based DSPD units and integrate them into the therapeutic community programme. It is unfortunate, especially in light of the challenges with progressing DSPD patients and prisoners to lower security facilities later identified in the thesis, that at the time of writing, the future of Grendon as a progression site for DSPD prisoners is in doubt because of funding issues.

Alongside the development of DSPD services, the DSPD Programme has also set up a research and development programme<sup>20</sup>. Each of the four high security units for men is expected to add to the Common Data Set (CDS) a database across all sites to enable comparison (see DSPD Programme (2008) for further information). Alongside this, several large evaluations have been commissioned including: the Prisoner Cohort study (Coid et al, 2007); an evaluation of the assessment procedure (the IMPALOX study) (Tyrer et al, 2007); a number of economic evaluations of the cost of DSPD services (the CODES study) (Barrett and Byford, 2007; Barrett et al, 2005; Barrett et al., 2007); an evaluation of assessment and treatment (the IDEA study); and an

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<sup>19</sup> See [http://www.dspdprogramme.gov.uk/progression\\_service4.html](http://www.dspdprogramme.gov.uk/progression_service4.html) for more information.

<sup>20</sup> See <http://www.dspdprogramme.gov.uk/research.html> for more information



evaluation of the management, organisation and staffing of the high secure units (the MEMOS study).

Despite attempts to introduce specific DSPD legislation, these plans were eventually shelved in 2006 (Seddon, 2008a). While DSPD services emerged within the context of existing law, the programme has been surrounded by a number of relevant changes to mental health and criminal justice legislation. This chapter now considers some of these wider developments before returning to DSPD to explore the reasons behind, and the challenges raised by, its emergence.

### **Wider mental health developments under New Labour**

High levels of mental illness amongst prisoners have long raised concern, with seventy-two percent of male prisoners considered to suffer from two or more mental health disorders (Prison Reform Trust, 2008a) and sixty-four percent considered to have a personality disorder (Singleton et al, 1998). Following Lord Ramsbotham's *Patient or Prisoner* report (Her Majesty's Chief Inspector of Prisons, 1996), there have been increasing calls to improve prison healthcare. In 2000 responsibility for policy development and standards of health care in prisons moved from the Prison Service to the Department of Health, and by April 2003, financial responsibility for health care in prisons transferred to the National Health Service (NHS) (See Sim (2002) and Seddon (2007) for more information).

Attempts to reform the MHA1983 have continued unabated since New Labour took office. In June 2002 the first Mental Health Bill was published (Department of Health, 2002). The Bill removed the separate category of psychopathic disorder in favour of a broader definition of mental disorder, amended the treatability test, and introduced provisions for compulsory treatment in the community. Peay (2003) argues that the Bill was driven by the need to make legislation compliant with Human Rights legislation, a

perceived need to extend compulsory treatment to the community, and a desire to bring those with DSPD within the ambit of the Act. The Bill however was met with some considerable criticism (Justice, 2002; King, 2002; Nacro, 2002; Royal College of Psychiatrists, 2002).

Huge resistance was reignited when the second Mental Health Bill was published in September 2004 (Joint Committee on the Draft Mental Health Bill, 2005a-c; Mental Health Alliance, 2005; Revolving Doors Agency, 2004). Many did not feel the government had satisfactorily responded to concerns about the first draft Mental Health Bill. The Mental Health Alliance<sup>21</sup> (2004), an umbrella network of over seventy-five organisations set up in response to the proposals to reform the MHA 1983, described the second Bill as ‘unfit for the 21<sup>st</sup> century’, while the Joint Committee on the Draft Mental Health Bill (2005a-c), concluded that it was ‘fundamentally flawed’.

In March 2006 proposals to introduce a new MHA were abandoned. Instead it was proposed that the existing MHA 1983 would be amended (Department of Health, 2006a). Despite ongoing criticism about the focus of reform, the Mental Health Act 2007 (hereafter MHA 2007) which amends the MHA 1983, received Royal Assent in July 2007, and came into force in November 2008. The amendments include: the removal of the category of psychopathic disorder, in favour of a general definition of mental disorder, defined as ‘any disorder or disability of the mind’ (s1(2)); the amendment of the previous requirement that treatment must ‘alleviate or prevent deterioration’ to ‘appropriate treatment is available’ (s3(2)d); and the introduction of Community Treatment Orders (CTOs) under s17a.

Alongside ongoing attempts to reform the MHA 1983, the National Institute for Mental Health in England and Wales (NIMHE) (now the National Mental Health Development

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<sup>21</sup> See <http://www.mentalhealthalliance.org.uk/index.html> for more information.

Unit (NMH DU)) has sought to ensure that people with personality disorder 'are seen as the legitimate business of mental health services' (NIMHE, 2003a:1, see also NIMHE, 2003b). The NIMHE have attempted to ensure that those with personality disorder are not excluded from services (NIMHE, 2003a) and that staff can respond effectively to the needs of people with personality disorder (NIMHE, 2003b). These developments have been reinforced by the National Personality Disorder Programme<sup>22</sup>, the Department of Health (2006b), and most recently the National Institute for Clinical Excellence (NICE, 2009a, 2009b). They indicate that the government has tried to make personality disorders 'everybody's business' (Pidd et al, 2005), and encourage psychiatrists and the health service to take responsibility for those with personality disorder. It is of note, however, that the National Personality Disorder Programme appears to 'embrace the DSPD pilots in a low-key fashion' (Peay, 2007:518).

### **Wider criminal justice developments under New Labour**

Developments elsewhere demonstrate that the governance of those with personality disorders remains the legitimate business of the criminal justice system and that DSPD is part of a much larger programme of reform. Significant developments include the establishment of Multi-Agency Public Protection Arrangements (MAPPA) in April 2001 under the Criminal Justice and Court Services Act (2000), the radical overhaul of the sentencing framework, probation and prison services in England and Wales following the Halliday (Home Office, 2001) and Carter (2003) reports, the Criminal Justice Act 2003, and the introduction of the National Offender Management Service (NOMS) in June 2004 (see Nash, 2006 for an overview).

MAPPAs require close working relationships between health, prison, social care, police and probation services to identify and make shared plans to actively manage the risk posed by dangerous offenders in the community (Kemshall and Maguire, 2001). They

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<sup>22</sup> See <http://www.personalitydisorder.org.uk> for more information.

highlight that the risks posed by sexual and violent offenders have become major political issues, and the landscape in regard to sex offenders, in particular, has been 'totally transformed' in the last twenty years (Rutherford, 2007:67). Sex offenders are now subject to increasing regulation and surveillance (Kemshall, 2003) following the introduction of the Sex Offenders Register under the Sex Offenders Act 1997, the introduction of Sex Offender Supervision Orders (SOSOs) under the Crime and Disorder Act 1998, and more recently the Sexual Offences Act 2003 which extended the definition of sexual offences, replaced SOSOs with Sex Offender Prevention Orders (SOPOs), and tightened notification requirements<sup>23</sup>.

The Criminal Justice Act 2003 (CJA 2003) received royal assent in November 2005 and further underscored the government's determination to protect the public from dangerous offenders. NOMS has overall responsibility for implementing the new sentencing provisions laid out in the CJA 2003. The CJA 2003 re-enacted and strengthened MAPPA provisions, and significantly, made explicit provision for new public protection sentences. Although extended sentences for violent and sexual offenders had been introduced under the Crime and Disorder Act 1998 and the Powers of Criminal Courts (Sentencing) Act 2000, the CJA 2003 introduced new powers for extended sentencing. This has served to 'blur boundaries' between detention in prison and supervision by the Probation Service (Rutherford, 2007) and make it increasingly difficult to 'know where the prison ends and the community begins' (Cohen, 1985 quoted in Rutherford, 2007:67).

More controversially the CJA 2003 introduced imprisonment for public protection (IPP) sentences. Where the court is of the opinion 'that there is a significant risk to members of the public' from an offender who has committed a serious offence as determined by

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<sup>23</sup> For an overview of sex offender legislation see Cobley (2005); Heberton (2008); and Thomas (2005).

Section 224, the Court must pass an indeterminate sentence, either a 'discretionary life sentence' (Section 225(2)) or a 'sentence of imprisonment for public protection' (IPP) (Section 225(3)). IPP sentences have been the focus of wide criticism, subject to several judicial reviews, and generated numerous problems for the prison service<sup>24</sup>. In March 2008, 10,911 people were serving an indeterminate sentence in England and Wales, of which 4,170 were serving an IPP sentence (HM Prison Service website). Although the Criminal Justice and Immigration Act 2008 has now introduced restrictions on the use of IPP sentences, in September 2008 it was estimated that an average of 140 people each week were being given an IPP sentence by the Courts (Ministry of Justice, 2008). This is likely to have implications for DSPD services, as research has already identified that fifteen percent of the IPP population would meet the criteria for DSPD (Coid et al, 2007).

### **Exploring the challenges raised by DSPD**

The DSPD proposals generated some considerable debate and criticism (see Birmingham, 2002; British Psychological Society, 1999; Buchanan and Leese, 2001; Chiswick, 2001; Coid and Maden, 2003; Cordess, 2002; Critical Psychiatry Network, 1999; Eastman, 1999; Gunn, 2000; Gunn and Felthous, 2000; Farnham and James, 2001; Haddock et al, 2001; Hudson, 2003a; Justice, 1999; Liberty, 2000; Moran, 2002; Morgan, 2004; Mullen, 1999; Peay, 2002, 2007; Prins, 2001; RCPsych, 1999; Sarkar, 2002; Smith, 2002; Sugarman, 2002; Walcott and Beck, 2000; Wooton and Fahy, 2006). Debate was sparked amongst psychiatrists, government and (to a lesser extent) the judiciary, about the appropriate response and responsibility for individuals with personality disorder.

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<sup>24</sup> For a review of the challenges see Prison Reform Trust (2008b); Sainsbury Centre for Mental Health (2008); HM Chief Inspector of Prisons and HM Chief Inspector of Probation (2008); ISP Review Group (2007).

Jack Straw, the Home Secretary at the time, accused psychiatrists of adopting a narrower interpretation of the law than in the past in order to wash their hands of 'dangerous psychopaths' (Steele, 2001). This demonstrates that psychiatry is no longer criticised for 'its excesses of social control, but its failures of social control and public protection' (Grounds, 1997 quoted in Blom-Cooper, 1999). Psychiatrists complained that they were being forced towards the role of 'society's jailer' (Laurance, 2003:xv) and in response to Jack Straw's observations, the then President of the Royal College of Psychiatrists observed that 'the Home Secretary can't expect psychiatrists to do his dirty work when it's at present excluded by the law' (Dr Kendall quoted in Warden, 1998:1270).

Some psychiatrists feared they were being asked to correct judicial mistakes and act as a political safety net for loop-holes in criminal procedure, observing that the government should refocus its attention on the fact that judges were only giving life sentences in two percent of cases (Eastman, 2002; Maden and Tyrer, 2003; Royal College of Psychiatrists, 1999). Two surveys at the time identified that eighty percent of psychiatrists did not support the government's proposals (Crawford et al, 2001) and that only twenty percent of forensic psychiatrists would be prepared to work in a DSPD unit (Haddock et al, 2001).

Many were at a loss to know where the term of DSPD had come from, complaining that it was a political term that did not correspond to existing clinical or legal categories or understanding (Buchanan and Leese, 2001; Chaplin, 2002; Eastman 2002; Farnham and James, 2001; Tyrer, 2000 in Titus 2004). In response to the proposals, Professor John Gunn, a leading forensic psychiatrist observed 'I don't know who these people are' (quoted in Yamey, 1999:1322). The introduction of DSPD was particularly problematic because of the confusion that already surrounds the legal term of

‘psychopathic disorder’, the clinical term of ‘personality disorder’, and the concept of ‘psychopathy’ (see Manning, 2000 and Peay, 2007:516-517 for a discussion).

Under the MHA 1983 (prior to amendments under the MHA 2007) the legal term of ‘psychopathic disorder’, is one of four categories of mental disorder, and is defined as:

[a] persistent disorder or disability of mind, whether or not including significant impairment of intelligence, which results in abnormally aggressive or seriously irresponsible conduct on the part of the person concerned (MHA 1983, s1(2)).

The term does not find much favour from a clinical perspective, with many considering it a moral judgment rather than a useful clinical diagnosis (Blackburn, 1998; Cavadino, 1998; Lewis and Appelby, 1988; Prins, 1999; Ramon, 1986). It is not recognised by the World Health Organisation’s *International Classification of Diseases* 10<sup>th</sup> Edition (ICD 10) (WHO, 1992) or the American Psychiatric Association’s *Diagnostic and Statistical Manual of Disorders* Edition IV, Revised (DSM-IV-TR) (APA, 2000). The ICD-10 and the DSM-IV have instead developed different clinical categories of ‘personality disorder’; identifying, nine and ten different types of personality disorder respectively (see Appendix E for more information).

The PCL-R (Hare, 1991) is an internationally recognised scale used to determine the presence of psychopathy and to predict future violent behaviour (Hare, 2006). The closest categories of personality disorder to psychopathy under the ICD-10 and DSM-IV are respectively, dissocial and antisocial personality disorder. Psychopathic behaviour is characterised by a number of traits including grandiosity, self-worth, pathological lying, lack of remorse/guilt, parasitic lifestyle, impulsivity, promiscuity, irresponsibility and criminal versatility. Twenty items are scored on a three point scale from 0-2 with a maximum score of 40 (see Appendix E for a list of the twenty items). A

score of between 25 and 30 is typically used as a cut-off point for psychopathy (Hare, 1999)

For a medical diagnosis to be credible, Pilgrim (2001) argues that it should be reliable, valid, its causes should be known, and it should be able to suggest treatment. Knowledge of the aetiological factors for personality disorder however does not exist and consequently the classification of personality disorder is reliant on descriptive features (Manning, 2000; Moran, n.d). This makes personality disorders 'notoriously difficult to detect since they manifest themselves through behaviours rather than through biological and psychological signs' (Timmermans and Gabe, 2003:13). Gender, socio-cultural biases, and the co-existence of personality disorders with mental illnesses and drug and alcohol use, make the assessment and diagnosis of personality disorder more difficult (Moran, n.d; see also Blackburn, 2000; Loring and Powell, 1988). The legitimacy of a personality disorder diagnosis is also problematic because it is made in an interpersonal context (Manning, 2000; Moran, n.d). This weak conceptual framework for personality disorders threatens the validity and reliability of a diagnosis of personality disorder (Moran, n.d) and suggests that many problems are involved with accurately identifying the DSPD group (Feeney, 2003).

Personality disorders, especially 'antisocial personality disorder' under the DSM-IV, have been criticised for their over-emphasis on deviance at the expense of personality disorder (Blackburn, 1988, Hare, 1998). This demonstrates that many consider personality disorder to be a circular or tautological diagnosis (Blackburn, 2000; Mullen, 1999; Wootton, 1959), which:

does little more than reaffirm a history of previous offences in a different (medical) language, thus generating a spurious association between personality disorder and offending (Critical Psychiatry Network, 1999:4).



The concept of DSPD is also problematic because there is no consensual system for measuring the severity of personality disorder (Dolan and Coid, 1993), with neither the ICD-10 nor the DSM-IV-TR offering a method for establishing severity (Feeney, 2003). In addition there is no proven link between the severity of personality disorder and dangerousness (Feeney, 2003) and some considerable resistance amongst psychiatrists to use the term 'dangerous'. The term has 'powerful and pejorative connotations' (Prins, 2002:5) and:

in view of the very vague definitions of 'dangerousness', the very low predictive accuracy ... the glaring overpredictions of such behaviour, and the involuntary and indeterminate loss of liberty that follows ... the labeling of the mentally ill as dangerous could in itself be regarded as a rather dangerous activity (Shah, 1975:505).

The history of risk assessment tools is characterised by an attempt to 'predict the unpredictable' (Kemshall, 2003) and to 'tame uncertainty' (Hacking, 1990). Risk prediction requires 'knowledge of the unknowable, certainty of the uncertain, and completion of the complete' (Williams and Arrigo, 2002:23). This highlights why assessing the risk of harm to others is a difficult and uncertain enterprise (McSherry, 2004; McAlinden, 2001). Despite common perceptions that psychiatrists are good at predicting future risk, the empirical evidence suggests they are not (Andrews and Bonta, 1998; Mason, 1998; see Kemshall, 2003 for a review). Research has shown that psychiatric judgments about dangerousness are usually no better than lay judgments (Gardner et al, 1996). Risk assessment tools are limited in accurately predicting rare events (Crawford, 2000; Kemshall, 2008; Menzies et al, 1994; Monahan and Steadman, 1996; Steadman et al, 1996; Szmulker, 2000) with the 'tendency to overpredict ... [deriving] ... from the comparative rarity of the conduct to be predicted'

(von Hirsch, 1998:99). The difficulty of course, is that these rare events are those that we most want to prevent (Kemshall, 2008).

While diagnostic labels are required for the legal recognition of mental disorder, they are limited in terms of treatment planning and needs (Blackburn, 1996; Pilgrim, 2001). This is particularly problematic in the case of personality disorder because the role of psychiatrists in assessment and treatment has long been an area of controversy (Collins, 1991; Cope, 1993; Lewis and Appleby, 1988; Manning, 2000; Moran, 1999). Research has found virtually no difference between those admitted to a secure hospital as treatable and those rejected as untreatable (Collins, 1991). This suggests that 'clinical judgments about treatability are even less reliable than those of dangerousness' (Quinsey, 1988:136 in Blackburn, 1996). Only twenty-eight percent of psychiatrists in a survey conducted by Haddock et al (2001) considered 'severe personality disorders' to be treatable. This highlights the growing assumption that 'nothing works' with personality disorder (Manning, 2000) and the replacement of psychiatric optimism about treatment with psychiatric pessimism (Peay, 2007; see also Simon, 1998). There is good reason for this pessimism according to Hare, (1999:191) because:

unlike most other offenders, psychopaths suffer little personal distress, see little wrong with their attitudes and behaviour, and seek treatment only when it is in their best interests ... therefore it is not surprising that they derive little benefit from traditional treatment programmes.

Feeney (2003:356) argues that 'by their very nature, individuals in the DSPD group will prove difficult to engage in treatment'. Those with personality disorders are more likely to have difficulty in building therapeutic relationships (Muran et al, 1994), more likely to be disruptive and unmotivated (Hemphill and Hart, 2002), show fewer signs of

improvement, and are less likely to complete treatment (Hemphill and Hart, 2002; Ogloff et al, 1990). Concerns have also been raised that treatment may make those with personality disorder even more dangerous (Hare et al, 2000; Rice et al, 1992) on the basis that they may 'have learned some psychological and social skills to be able to be better and more effective psychopaths in future' (Morris, 2004b:45; see D'Silva et al, 2004 for a review of the evidence).

Although there is growing evidence that psychodynamic therapy (Bateman and Fonagy, 1999, 2000, 2001; Perry et al. 1999) and placements in therapeutic communities are effective at managing and treating those with personality disorders (Dolan, 1998; Dolan and Coid, 1993; Hollin and Palmer, 2006; Lees et al, 1999; Warren et al, 2003), research concerning the success of treatment has been inconclusive and there is no evidence that those with personality disorder can be treated, or that they are untreatable (Dolan and Coid, 1993; Blackburn, 1993a, 1993b, 2000; Garrido et al, 1996; Hemphill and Hart, 2002; Lösel, 1998; Warren et al, 2003).

Treatment success is difficult to assess because of conceptual and methodological difficulties (Dolan and Coid, 1993; Hemphill and Hart, 2002; Royal College of Psychiatrists, 1999; Warren et al, 2003). It is not always 'clear what is meant by treatment or what treatment is trying to alter' (Peay, 2007:511; see also Blackburn, 1996). Clinical success is increasingly assessed in terms of reoffending (Blackburn, 1996; Dolan and Coid, 1993) and questions of risk rather than issues of health (Peay, 2003). However, 'psychiatric services in the UK were not set up to prevent criminal recidivism as a primary goal' (Royal College of Psychiatrists, 1999:47) and the use of 'criminological criteria to assess the usefulness of psychiatric intervention is ... mistaken in principle and impossible in practice' (Robertson, 1989 quoted in Royal College of Psychiatrists, 1999:48).

While the ‘treatability’ of personality disorder may remain unknown, the significance of psychopathy as a risk factor for violence and reoffending is well established (Blackburn, 1993a; Hare, 1999, 2006). Offenders with personality disorder are considered to be ‘responsible for a disproportionate amount of serious repetitive crime and violence in our society’ (Hare et al, 1992:289 in Fine and Kennett, 2004). They are more likely to be violent in prison (Hare and Hart, 1993), and following release they are more likely to be reconvicted at a higher and faster rate than offenders without personality disorder (Bailey and MacCulloch, 1992b; Hare et al, 2000; Hemphill and Hart, 2002; Hemphill et al, 1998; Jamieson and Taylor, 2004; Steels et al, 1998). A recent study conducted in a high security hospital in England found that those with personality disorder were seven times more likely than those with mental illness to be convicted of a serious offence after discharge (Jamieson and Taylor, 2004:783-800).

These observations highlight that the appropriate governance of those with personality disorder is a long standing problem, and that it is unclear if they should be detained in hospital for treatment, or in prison for punishment. The development of DSPD services in both health and criminal justice settings has exacerbated this uncertainty, and exposed that: little is known about personality disorder (Shea, 1993); ‘far more has been written about the subject than is actually known about it’ (Hemphill and Hart, 2002); and that, ‘perhaps the only thing about personality disorder on which every written authority agrees is that nobody comprehensively knows what it is’ (Bowers, 2002:2).

The introduction of DSPD services has also raised important ethical issues. Fitzgibbon (2004) argues that the DSPD programme is likely to generate a high number of false positives<sup>25</sup> because it is based on a strategy of exclusion. Others are concerned that

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<sup>25</sup> False positives are defined by Champion (2007:37) as ‘persons believed to pose risks to society who in fact do not’. See von Hirsch (1998) for further discussion.

every year, six people with DSPD would have to be detained in order to prevent one person from acting violently (Buchanan and Leese, 2001). Eastman (2002:65) argues that:

[i]f civil liberties are to be removed on the basis of newly developed science (of assessment and treatment) then that new science should precede the law and not the reverse.

This reminds us that despite New Labour's preference for evidence-based policy, the DSPD units have emerged in a far from evidence-based context. This absence of an evidence-base and the problems that arise from it, have already been observed by Peay (2007:517-518):

This is not to be an evidence-based programme. And how, anyway, could it be? If there is no agreed definition, no clear diagnosis, no agreed treatment, no means of assessing when the predicted risk may have been reduced, and no obvious link between the alleged underlying condition and the behaviour, how could outcome measures be agreed upon and then evaluated?

### **Making sense of New Labour's approach to offenders with personality disorder**

The emergence of DSPD is less surprising when placed in the context of a risk society. Risk, and our preoccupation with its assessment and management have become pervasive in late modernity (Beck, 1992, 1998; Douglas, 1992; Feeley and Simon, 1992; Giddens, 1991; Loader and Sparks, 2007; Lupton, 1999; O'Malley, 2004a; Sparks, 1997, 2001) and is at the heart of the public protection agenda (Solomon, 2008) and the governance of mentally disordered offenders (Brown and Pratt, 2000;

Corbett and Westwood, 2005; Glover-Thomas, 2002; Gray et al, 2002; Gunn, 1996; Hudson, 2003b; Kemshall, 2003; Peay, 2002; Petch, 2001; Rose, 1998). In late modernity, risks have become more incalculable (Beck, 1992) and unknown, while at the same time becoming ever more omnipresent (Giddens, 1991). 'Calculating and managing risks which nobody really knows has become one of our main preoccupations' (Beck, 1998:12; see also Hacking, 1990) with the management of dangerous offenders now requiring us to think the 'unthinkable' and ask the 'unaskable' (Prins, 1988:604).

High profile events like the Michael Stone case helped expose the perceived failures of deinstitutionalisation and care in the community. That Michael Stone was already known to services served to heighten the public's feeling of broken trust. Such tragedies are no longer understood as the result of fate but as an unintended consequence of modernity (Giddens, 1991) and the failure of professional expertise for which someone must be responsible and accountable (Rose, 1998). 'Whose fault? Is the first question' (Douglas, 1992:16). This highlights that our trust in experts (Beck, 1991; Garland, 2001; Giddens, 1991; Kitzinger, 2004) and in their methods for assessing and managing risk (Kemshall and Maguire, 2001; Power, 2007; Solomon, 2008) is diminishing.

Public and political interest in penology is heightened when things go wrong and subsequent questions of accountability and legitimacy emerge (Kemshall, 2008; Sparks, 2000a; 2000b). A key feature of modernity 'is the necessity of establishing "the facts" in situations where something has gone wrong, and taking rational and systematic steps to rectify the situation' (Webb and Harris, 1999:2). Many strategies have been developed to find out what has gone wrong, including the introduction of compulsory inquiries into all homicides committed by those known to mental health services, supervision registers, and guidance on discharge (Department of Health,

1994). A number of inquiries have exposed some of the problems involved with managing the risk of 'dangerous' and/or 'mentally disordered' offenders (Blom-Cooper et al, 1992, 1995, 1996; Boyd, 1996; Fallon et al, 1999; HMIP, 2006a, 2006b; NHS London, 2006; Ritchie et al, 1994; South East Coast Strategic Health Authority, 2006; Tilt et al, 2000)<sup>26</sup>.

Seddon (2007:144) argues that 'being seen to respond quickly and robustly to the apparent legal anomalies revealed by the Michael Stone case was critical', and in practice, the '*announcement* of the policy was as important as its actualisation'. Nash (2006:74) argues that the DSPD proposals were a 'clear example of policy flying in the face of expert opinion'. This move in the absence of evidence and professional consensus suggests a 'tendency for politicians and moral entrepreneurs to reach over the heads of the professionals to the feelings and intuitions of voters and newspaper readers' (Sparks, 2000b), and highlights that the eruption of scandals via the media 'have consistently proved catalysts for changing policies' (Downes and Morgan, 2002:287).

These developments suggest that we have moved from an elitist model of penal policy to a more populist model (Johnstone, 2000; Ryan, 1999). This has led some to observe the rise of 'populist punitiveness' (Bottoms, 1995) a 'new punitiveness' (Pratt, 2000b; Pratt et al, 2005) and 'penal populism' (Pratt, 2006). Johnstone (2000:161) argues that the government is now 'more keen to engage the public than to exclude it' (see also Garland, 2001; Ryan, 1999; Solomon, 2008). The public, however, are often painted as more punitive than they actually are (Hedderman, 2008; Hough, 1996; Tonry, 2003), and:

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<sup>26</sup> Many more inquiries could be listed. For further discussion regarding the significance of inquiries see Grounds (1997); Manthorpe and Stanley (2004); and Peay (1996).

there is a division between those who see this surge in punitiveness as being driven from 'below' by an anxious and angry general public and those who see it as an essentially 'top down' process in which ambitious and manipulative politicians play on public fears and anxieties in order to get tough on crime and to increase their electoral support (Matthews, 2005:176).

Whether it is public or politically led, ethical and civil liberty concerns have had a decreasing influence on legislators (Kemshall and Maguire, 2001; Kemshall, 2003) and mental health policy has taken an 'increasingly coercive appearance' (Cutcliffe and Hannigan, 2001:315). Since the reversal of the just deserts emphasis in the Criminal Justice Act 1991 in 1993 and the famous proclamation of the Conservative Home Secretary Michael Howard that 'prison works', the prison population has risen year on year. Sentences are getting longer (Millie et al, 2003), especially for those considered to be dangerous (Levi et al, 2007; Morgan and Liebling, 2007; Peay, 2007). Furthermore, sentencing has been increasingly aimed at public protection rather than just retribution and deterrence (Levi et al, 2007; see also Garland, 2001; Hudson, 2002a; Nash, 2006; Peay, 2007; Prins, 2002). This highlights a 'morbid governmental preoccupation with the need for public protection' (Prins, 2002:07; see also Kemshall, 2008; Nash, 2006) and a:

new and urgent emphasis upon the need for security, the containment of danger, the identification and management of any kind of risk. Protecting the public has become the dominant theme of penal policy (Garland, 2001:12).

This has shifted the focus from punishing past violations to one of preventing future crime through incarceration and the control of dangerous offenders (Robinson, 2001). This has led to the growth of preventive and punitive legislation (Kemshall, 2008; Matravers and Hughes, 2003; Nash, 2006). Punishment is now 'required to fit the



potential risk as well as fit the crime' (Kemshall, 2008:29). It is now *potential* rather than *actual* dangerousness that is driving the agenda (Nash, 2006:3). Fitzgibbon (2004) argues that despite a New Labour rhetoric of social inclusion, DSPD is an exemplar of 'pre-emptive criminalisation', where risk and public protection override treatment. This highlights a 'significant shift from *doing justice* to *controlling risk* as the goal of law and order strategies' (Hudson, 2002a:101; see also Denney, 2005). In the context of DSPD, Peay (2007:518) argues that it is:

hard to resist the sense that the initiative stems not only from concerns about treatment, justice or due process, but explicitly from anxiety about reoffending by those 'prematurely' released from the hospital or prison system.

Matravers and Hughes (2003:76) argue that 'it is important to end the cyclical process by which public fears give rise to populist public policies which reinforce public fears'. The introduction of evermore initiatives and legislation raises public expectations and the gap between what is promised and what is possible (Solomon, 2008). Inquiries and legislation have, rather than provide reassurance, served to reinforce the public's link between mental disorder and violence towards strangers (Peay, 1996), fuelled a moral panic within mental health services (Holloway, 1996; Pearson, 1999; Prins and Swan, 1998), generated numerous problems for psychiatric practice (Szmulker, 2000), eroded confidence in policies of care in the community (Laurance, 2003; Morrall, 2000; Crichton and Sheppard, 1996:65), and enabled a discourse of containment to gain increasing respectability (Moon, 2000). This is despite the fact that the number of murders committed by mentally disordered offenders actually fell during the 1990s (Taylor and Gunn, 1999) and into the 2000s (Large et al, 2008).

Explanations and descriptions of risk in criminology have often centred around Feeley and Simon's (1992) claim that a 'new penology' has emerged based on actuarial

techniques for identifying and managing groups arranged by dangerousness. Actuarial justice is concerned with the probabilistic calculation of risk and the statistical distribution of different populations rather than individual characteristics. This penology, in contrast to earlier forms, is concerned neither with the responsibility or fault of the individual, nor with their treatment; instead, the new penology has a managerial rather than transformative task. 'The new penology is generally agnostic towards treatment. The goal is waste management' (Simon, 1998:456).

The extent to which actuarial justice has displaced other traditional penological practices has been subject to much debate (Garland, 1995; Leacock and Sparks, 2002; Pratt 2000a, 2000b; O'Malley, 2000, 2004a, 2004b; Robinson, 2002; Sparks, 2000a). Many have observed that risk is a heterogeneous array of practices that can have varying effects and may take several forms, including treatment and the identification of offender needs (Douglas, 1992; Hannah-Moffatt, 2005; O'Malley, 2004a; Sparks, 2001). Furthermore, risk discourse is not as static as actuarial justice suggests, but ever shifting (O'Malley, 2004a), and criminologists have a 'responsibility to consider the promise, as well as the problems of risk' (O'Malley, 2008:453).

Statistical probabilities are only one method of estimating the probability of harm, and clinical judgments inform many assessments in the criminal justice system (O'Malley, 2000). Given that DSPD proposals preceded actuarial evidence of their efficacy, it would appear that they are the result of heightened public and political insecurity rather than enhanced abilities to detect and manage risk. Seddon (2007:148) argues that:

[r]isk assessments in the DSPD programme ... revolved much more around 'technologies of uncertainty' than probabilistic assessments of actuarial risk ... [The] 'risk factors' that might be used to assess individuals for DSPD ... were not really numerical or probabilistic in form.

While policies like DSPD are clearly set up to contain groups of people deemed risky by their membership of a wider group, Lacombe (2007) argues that the DSPD programme is more concerned with transforming and changing the offender than the 'new penology' thesis allows for. Most accredited offender behaviour programmes focus on the offence (Debidin and Lovbakke, 2005) but treatment in the DSPD units is more offender-focused, demonstrating an increasing recognition that treatment needs to be focused on the offender (Blackburn, 2004). This indicates that 'there is no obvious reason why risk cannot be inclusive and reformist rather than exclusionary and merely incapacitating' (O'Malley, 2008:453) and highlights the emergence of a '*transformative risk subject* who unlike the *fixed or static risk subject* is amenable to targeted therapeutic intervention' (Hannah-Moffat, 2005:29). DSPD suggests a shift from simply containing a group of people to be managed to a more interventionist strategy concerned with both public protection and questions of 'what works'.

For a long time, mentally disordered and personality disordered offenders have been described as 'outliers' (Harris, 1999), 'unwanted packages' in a game of 'pass the parcel' (George, 1998), 'nobody's business' (Pidd et al, 2005), and a group that 'nobody owns' (Webb and Harris, 1999). Offenders with personality disorder have often been denied treatment and passed between a number of services including the prison service and the 'notorious but little understood world[s]' of the Special Hospitals (Kaye and Franey, 1998:13). At the stage of sentencing, individuals with a diagnosis of personality disorder are more likely to be given a prison sentence than a hospital disposal. This demonstrates that those with personality disorder have often been turned away from the mental health system on the basis of untreatability (Akuffo, 2004) and that admissions to hospital are rare (Ly and Foster, 2005) and arbitrary (Maden, 1999, see also Quinsey, 1988). Once in the prison service, individuals with a high PCL-R score are often excluded from traditional prison service treatment programmes on

the basis that they are unlikely to engage with or benefit from treatment (Morris, 2004b).

As a result, it could also be argued, that those with personality disorders are also people who 'nobody knows'. Years of debate have failed to clarify who these people are, who should take responsibility for their care and management, whether they should be punished or treated, and perhaps most problematically, if they can be treated at all. It is within this uncertain and unknown context that the DSPD concept, programme and units have emerged. Now, answers to these debates are being sought, and in this respect the development of DSPD services represents an effort to know the unknowable.

The DSPD patients and prisoners could be described as 'unknowable' not only because of the weak understanding about who they are or their risk of offending, but also because of their 'chameleon like ability' to 'place themselves beyond the law' (Pratt, 1997:27). The emergence of the term 'psychopath' and associated legislation in the early 20<sup>th</sup> century, followed the need to 'explain otherwise inexplicable behaviour' and to govern those who were 'unpredictable, unknowable, uncontrollable, ungovernable by the usual penal strategies and therefore highly dangerous' (Pratt, 1997:97). The unknowability of those now described as DSPD provoked the government into action to try and prevent their risk. This highlights that being 'unknowable' confirms a status of dangerous (Pratt, 2000a) and that paradoxically, sexual offenders are:

held to be little more than non-human 'fiends, 'beasts' and 'monsters'. But ... are also everpresent, unknown (and sometimes unknowable) both to their 'victims' (or potential 'victims') and to themselves. In this they are constituted as all-too-human, as 'ordinary' people (Phoenix and Oerton, 2005:195).

According to Morris (2004b:47) offenders with a high PCL-R score became the ‘folklore “bogey men” of criminal justice rehabilitation’ during the 1990s. This ‘demonization’ of offenders with personality disorder is ‘itself a psychopathic reaction to the personal and professional challenges that this group represent’ (Morris, 2004b:43). The exclusion of high PCL-R scorers is based on interpretation and what may be more dangerous is underestimating the ability of those with lower PCL-R scores to change (Morris, 2004b). The situation however, is beginning to change, because ‘personality is coming back into fashion’ (Blackburn, 2000:1; see also Peay, 2007) and ‘the nettle has been grasped [that] this group will not go away, and have a right to rehabilitative efforts along with offenders who are less psychopathic’ (Morris, 2004b:43).

This has led to the development of specific programmes targeted at this group that are ‘designed to fill the lacuna in the provision of treatment’ (Arnold and Creighton, 2006:46). These include the Violence Reduction Programme (Wong, 2000a, 2000b) the DSPD Programme (Morris, 2004b) and Chromis, an intervention designed specifically to reduce recidivism in violent offenders with a PCL-R score of 25 or more. These programmes can be situated in a wider renewed interest in ‘what works’ with offenders in the 1990s (Lacombe, 2007; McGuire and Priestley, 1995; Roberts, 1995; Shuker, 2004).

Offending behaviour programmes have become the ‘cornerstone’ of prison and probation based rehabilitative work (Debidin and Lovbokke, 2005) and a number of psychological therapies, including Cognitive and Dialectical Behavioural Therapies (CBT and DBT) and constructive approaches to working with offenders (Hollin and Palmer, 2006; Gorman et al, 2006), have been developed. By 2005 the prison service had nineteen offending behaviour programmes and two therapeutic communities

accredited by the Correctional Services Accreditation Panel (CSAP)<sup>27</sup> (Debidin and Lovbokke, 2005). These developments suggest that 'rehabilitation is making a comeback' (Cullen, 2005:3) and 'enjoying a renewed legitimacy' (Robinson, 2008:429; see also Moore and Hannah-Moffatt, 2005; Robinson, 2002):

Whilst there was this very punitive trend, it was also matched by to some extent the beginning of 'we've got to do something with these men' ... treatment was beginning to creep back into the vocabulary (Elaine Player quoted in Seddon, 2007:116-7).

According to Robinson (2008:429), the concept of rehabilitation has survived because it has evolved and remarketed itself to appeal to three dominant penal narratives, namely: utilitarian, managerial and expressive. Although the 'state's right to punish rests on its contractual obligation to address the social problems that cause lawbreaking' (Carlen, 1994 cited in Lewis, 2005:123; see also Sparks, 2000), today, rehabilitation is justified in utilitarian terms as protecting the public, rather than welfaristic concerns for the offender (Robinson, 2008). Communities and victims are positioned as the main beneficiaries (Robinson, 2008; see also Farrant, 2006; Garland, 2001; Raynor, 2004). Now, 'it is future victims who are "rescued" by rehabilitative work, rather than the offenders themselves' (Garland, 1997:6).

Rehabilitation is also justified in managerialist terms, as demonstrated by the end-to-end offender management focus of NOMS, which assigns people to risk categories and constructs them as 'risk bearing subjects' (Robertson, 2008). Now we must know (dangerous) offenders at all stages of the criminal justice system; they must not escape from the net. In this sense risk takes on a form of 'targeted governance' (Valverde and Mopas, 2004 in Maurutto and Hannah-Moffat, 2006) where offenders must 'become

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<sup>27</sup> The CSAP replaced the General Accreditation Panel, first set up in 1996.

known in order to be governed' (McCallum, 2001:36) and be made 'knowable, calculable and comparable' (McKinlay and Starkey, 1998 in Farrant, 2006).

Rehabilitation also fits with the expressive needs of punishment and the emergence of a 'new punitiveness' (Pratt et al, 2005; Robinson, 2008). In the name of rehabilitation, prisoners can be allocated to higher security for treatment; a punitive move that can be justified by a therapeutic focus on offender needs (Hannah-Moffat, 2005). The 'punitive act is translated into a therapeutic one' (Moore, 2007:50). This alignment of rehabilitative and punitive strategies enables the development of a number of hybrid strategies that enable a focus on the individual, but also have the capacity to exclude (Robinson, 2008; Farrant, 2006). Several criminal justice policies are increasingly structured by policies of exclusion (Bauman, 2000; Garland, 2000; Young, 1999), and forms of 'risk-based segregation' (Kemshall, 2008:40). This is evident by the increasing focus on third way and hybrid strategies for the management of dangerous offenders (see Cabinet Office, 2007).

These observations suggest above all that rehabilitation and a focus on 'what works' have survived because they have adopted the language of risk (Hannah-Moffat, 2005; Kemshall, 2003; Robinson, 2002, 2008). 'Rehabilitation is entirely entrenched in the language of risk ... rehabilitation has become risk management' (Lacombe, 2007:18; see also Fennell, 2002; Garland, 2001; Robinson, 2008). A focus on offender needs may be structured 'in terms of risk reduction and "intervenability"' rather than what an individual offender requires (Hannah-Moffat, 2005:38). Today, 'what works' is what works to reduce reoffending<sup>28</sup>.

This analysis demonstrates the importance of risk for the DSPD programme. Gray et al (2002:3) argue that what may be significant about the emergence of DSPD services

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<sup>28</sup> See <http://www.crimereduction.homeoffice.gov.uk/workingoffenders/workingoffenders1.htm>

is that for ‘the first time in the history of our criminal justice and mental health systems ... individuals are to be indefinitely detained on the basis of risk’. In contrast, Seddon (2007:142-153) argues that while risk is an important structuring feature, it is not an ‘exclusive or overriding one’, and other older strategies of managerialism, penal populism and humanitarianism can still be identified. This reminds us that concerns about risk and uncertainty have a long history (O’Malley, 2004a) and that a commitment to public protection is nothing new (Pratt, 1997; Pratt, 2000a).

It may also be possible to overstate the novelty of the DSPD Programme (Seddon, 2007) and its focus on ‘what works’. ‘Dangerous individuals’ and ‘psychopathy’ are roughly the same age as the modern prison (Rhodes, 2004) and debates about the appropriate response have a long history (Bottoms, 1977; Butler Committee, 1975; Floud and Young, 1981; Peay, 1988; Walker, 1991). ‘Arguably in the 1950s the solution was Grendon; in the 1990s it is DSPD’ (Morris, 2004a:1999). It is also important to remember the high levels of psychopathy amongst Control Review Committee (CRC) special unit prisoners in the early 1990s (Coid, 1991) and that specific treatment wards for patients with personality disorder in the mental health system have been around for some time (Brett, 1992; Grounds et al, 1987; Norton, 1992). Peay (2007:518) observes that:

cognitive behaviour programmes for ‘psychopaths’ are already part of the ‘What Works’ agenda in prisons. Moreover, of the four DSPD pilot schemes, two are sited in prisons. To what extent this reveals an emphasis on containment rather than treatment, or the tacit recognition that treatment may not be successful, is unclear.

What may be new about DSPD is that it is structured by a ‘precautionary logic’ which has developed in response to a ‘zero-risk problematic’ (Ewald, 2000:378). The



management of high risk offenders now involves the identification of prevention of risks to the public, 'with zero risk an unstated but implicit aim' (Kemshall, 2008:85). In this context, 'uncertainty is no longer an excuse [and] false "negatives" (incorrectly rating a person as 'safe') cannot be tolerated' (Hebenton and Seddon, 2009:4-10). In this context, professionals come under increasing 'obligation' to '[act] in the present in order to manage the future' (Rose, 2002:212). This moves our focus beyond traditional concerns for probabilistic risk, towards possibilistic concerns about the 'worst case scenario' (Clarke, 2006; Furedi, 2009).

Drawing from Ericson's (2007:24-31) discussion of how precautionary logic has led to the increasing criminalisation of uncertainty, Hebenton and Seddon (2009) argue that its two strategies of 'the deployment of law against law' and the 'creation of new surveillant assemblages' can be seen in the development of DSPD services.

In terms of the deployment of law against law they argue that by attempting to remove the treatability test of the MHA 1983 and introducing specific DSPD legislation the government 'explicitly constructed the problem in terms of the need to circumvent legal barriers to the effective use of confinement for the control of risk' (Hebenton and Seddon, 2009:348). This highlights a strategy of 'loophole plugging' (Nash, 2006) to ensure that dangerous and 'unknowable' offenders do not slip through the net. Peay (2007:498) observes that, before the MHA 1983 could be amended, many of the government's objectives were achieved by the introduction of MAPPA arrangements and the CJA 2003 (Peay, 2007:498). MAPPA, and other developments including the introduction of Community Treatment Orders under the MHA 2007 indicate that "'care in the community" has become "control in the community"' (Kemshall, 2008:36).

Uncertainty has been criminalised in other ways under New Labour with the introduction of: Sexual Offences Prevention Orders (SOPOs) and Risk of Sexual Harm

Orders (RSHOs) (Shute, 2006; see also Kemshall and Wood, Nash, 2006), policies to deal with 'potentially dangerous persons' (Rutherford, 2007), Anti-Social Behaviour Orders (ASBOs) (Rutherford, 2000), and DSPD (Fitzgibbon, 2004; Walcott and Beck, 2000). These developments demonstrate an increasing reliance on civil and pre-emptive measures (Fitzgibbon, 2004; Janus, 2000; Rutherford, 2000; Walcott and Beck, 2000) and suggest that 'a cornerstone of New Labour's emerging criminal policy is reliance on civil procedures with a criminal sting' (Rutherford, 2000:33).

The creation of new surveillant assemblages is evidenced by a number of developments. A preoccupation with dangerous offenders has driven the multi-agency agenda and the development of 'networks of surveillance' (Kemshall and Maguire, 2003:192; see also Kemshall, 2008; Kemshall and Maguire, 2001; Maguire et al, 2001; Prins, 2002; Rose, 1998). This is also evident with the development of NOMS and its focus on the end-to-end management of offenders. Surveillance has dramatically stepped up in the prison service (Morgan and Liebling, 2007) and the mental health system (Exworthy, 2003; Tilt et al, 2000). Today, a wide range of professionals must work together to secure the 'surveillance and communication designed to minimise the riskiness of the most risky' (Rose, 1998:189). This has led to the proliferation of multi-disciplinary teams, as professionals come together to answer: 'what is to be done and how can we decide' (Rose, 1998:186). Lieb (2003 in Kemshall and Wood, 2009:60) argues that problem-sharing amongst multi-disciplinary teams reflects the emergence of 'joined up worrying' and the sharing of anxieties about future blame.

These surveillant strategies remind us that 'knowability and calculability are essential to risk avoidance' (Kemshall, 2003:33). Managing the risk presented by those with DSPD is not simply a matter of containing those who are considered a risk, but now also involves the generation of 'knowledge that allows selection of thresholds that define acceptable risks and on forms of inclusion and exclusion based on that knowledge'

(Ericson and Haggerty, 1997:41). 'Knowing' the personality disordered offender is as central to governing their risk as containing them. The problem may be that 'while there are a number of significant issues in 'knowing' high risk or dangerous offenders, policy, legislation and practice are all conducted as *if* we can know them' (Kemshall, 2008:13; see also Ericson, 2005). The key question, according to Kemshall (2008:07) is 'can we know them?' This question strikes right to the heart of the difficulties that surround high risk offenders, and leads us to another important question, that this thesis indirectly explores: what are the consequences for decision-making of trying to know them?

## Conclusions

The policy, legislative and service developments that relate to DSPD highlight the increasing uncertainty and complexity that surrounds policy-making about dangerous offenders. The emergence of DSPD services prior to an evidence base demonstrates a growing 'appreciation that governments cannot legitimately keep up the idea that decisions can only be made once appropriate knowledge is available', the 'demise of the myth of absolute knowledge' and that policies must be developed under conditions of 'radical uncertainty' (Hajer and Wagenaar, 2003:10). Today, decisions must be made before knowledge can be generated, in order to pre-empt the risks we face.

DSPD is clearly part of a larger political agenda to protect the public from violent and sexual offenders. The plethora of criminal justice, mental health and civil legislation under New Labour demonstrates the increasing precautionary logic that structures the governance of offenders. This has involved the deployment of 'counter-law' and the creation of new 'surveillant strategies' (Ericson, 2007; Hebenton and Seddon, 2009) to capture those who we fear may otherwise escape from existing mechanisms of control. This has led to our increasing reliance on multi-disciplinary, hybrid, and knowledge-generating solutions.

While DSPD is clearly associated with the growing public protection agenda, this chapter has argued that the developments surrounding DSPD are also structured by concerns for establishing 'what works' and knowing more about offenders with personality disorder. Despite the controversy that surrounds DSPD, this is a perspective that has begun to receive attention. Mullen (2007:s3), a leading forensic psychiatrist from Australia writes:

The dangerous and severe personality disorder programme was born out of a populist law and order reaction, developed on false premises, but is now evolving into an exciting initiative for providing effective services to a group of offenders with mental illness who psychiatry, and the justice services, have so long ignored.

This renewed focus on what works has been structured by risk and a concern for public protection, rather than a concern for the welfare of the offender. It is a consequence of previous strategies of excluding those with personality disorder from treatment, and doing little more than 'containing' them, failing to keep hold of our feelings of insecurity. Today, providing little more than containment is no longer considered a safe option. Instead, and in order to guarantee our safety, we are increasingly driven by a need to 'know' the personality disordered offender. The question this raises, of course, has already been identified by Kemshall (2008:7) who asks: 'can we know them?'

While it is encouraging that new services have been developed for a neglected group and we have become increasingly interested in 'knowing' the offender with personality disorder, it is crucial that we consider how decision-makers from the PB and MHRT make sense of these developments. In conditions of 'radical uncertainty' policy makers must be 'made aware of the limits of the (quickly) knowable' (Hajer and Wagenaar, 2003:10). The uncertain foundation on which DSPD has been built may pose particular

problems for decision-making about DSPD patients and prisoners because our renewed interest in knowing is not yet accompanied by developments in understanding. At this stage, much about DSPD remains unknown. It is likely that the precautionary logic that has structured the development of DSPD services and wider criminal justice and mental health legislation will impact on how DSPD patients and prisoners respond to DSPD services, and on the decision-making of external decision-makers like the PB and the MHRT. Throughout the thesis it will become evident that our desire to know the unknowable, and the introduction of unknown services to manage and treat a population, who are also unknown, does indeed generate anxieties that have implications for PB and MHRT decision-making and the future progression of DSPD patients and prisoners.

### 3. Tracing the methodological journey

*The traveller explores the many domains of the country, as unknown territory or with maps, roaming freely around the territory. The traveller may also deliberately seek specific sites or topics ... the journey may not only lead to new knowledge; the traveller may change as well (Kvale, 1996:3-4).*

#### Introduction

As with the patients and prisoners on which this study is based, both the research and the researcher, made several journeys before the study developed into the form in which it is presented today. Along my research journey many pathways were uncovered, and while many were relatively easy to follow, others were simply inaccessible or only became available after much perseverance.

During the early stages of my fieldwork I was advised to revisit Genders and Player's (1995) methodological account of their research at Grendon Underwood. Their account offers a helpful insight into the reality of conducting research in a prison setting, and helped me to appreciate that some of the challenges I was facing were not problems as such, but simply part of the business of undertaking research in high security settings.

Genders and Player (1995), like others (Crawley, 2004; King, 2000; Sparks et al, 1996) identify that research in prisons cannot often be simply and neatly designed in advance and then carried out in accordance with a pre-ordained plan. The options available at each stage of the research depend on how previous stages have been handled (Wolf, 1991), and the information a researcher is able to access, in what format, and from whom, is largely dependent on the skills and personality of the researcher (Genders

and Player, 1995). This demonstrates that the viability of prison research is often the result of a number of 'make or break' factors (Genders and Player, 1995:19), and a 'grab-bag' approach that draws on a number of different methods (Smith and Wincup, 2000:335).

The uncertain nature of research in high security settings has often meant that researchers are not explicit enough about their methodology (Cohen and Taylor, 1972; Genders and Player, 1995; King, 2000), preferring instead to present a 'heroic tale' (Lee, 1999 in Smith and Wincup, 2000). Inspired by the honesty and explanation of the methodological accounts above, this chapter outlines the methodological journey of my PhD. I begin with a rather sanitised account of my research journey, before turning to explore some of the challenges that I encountered along my way.

### **The never-ending journey: securing access to the most high profile units in the country**

Originally, my thesis aimed to explore the emergence of the DSPD programme, and to place it within the context of ongoing mental health and criminal justice reform. Using a governmentality (see Burchell et al, 1991; Dean, 1999; Foucault, 1991; Miller and Rose, 2008) and interpretative policy analysis framework (see Fischer and Forrester, 1993; Fischer, 2003; Hajer and Wagenaar, 2003), I sought to develop a 'history of the present' (Garland, 2001) and explore why the DSPD programme emerged, in this form, at this time.

In order to develop this, I proposed to make good use of the vast array of policy and parliamentary documents surrounding DSPD, and to interview key policy-makers and members of the Mental Health Alliance. I negotiated access to observe Mental Health Alliance steering groups and to interview key members of staff from the Royal College

of Psychiatrists and Rethink (a mental health charity). I was also in discussion with a number of other relevant professional groups.

This focus and strategy largely followed from my assumption that access to the staff, patients and prisoners within the DSPD units was likely to be difficult, if not impossible. Although I expected access to policymakers to also have its challenges, I hoped that a workable study, not wholly dependent on access, existed. In hindsight my assumption that access to policymakers would be easier to secure was perhaps naïve, but to my surprise, very helpful, for actually securing access to the pilot units.

On receipt of my letter to the DSPD Programme, the Head of Research agreed to meet with me. The meeting went well, and took an unexpected turn, when he revealed that the DSPD Programme were about to confirm a research contract, and that, with the support of the research team, there may be ‘criminological’ elements of the research that I could become involved with. If I wanted an opportunity to study DSPD, he advised that I make contact with the lead researcher. I did.

I met with the lead researcher from Imperial College, who outlined the ‘Multi-method Evaluation of the Management, Organisation and Staffing (MEMOS) in high security treatment services for people with DSPD’ study. The focus of this study is primarily with the staffing of the DSPD pilot units, but having looked over their research proposal, I identified that I was particularly interested in their intention to consider the impact of the policy and the legislative framework on the units, the significance of the legal status of DSPD participants, the process and outcome of PB and MHRT reviews, and the significance of these reviews for the management of DSPD patients and prisoners. I agreed to develop a proposal of how I would incorporate the aims of my PhD with the new focus available to me through collaboration with the MEMOS study. Following submission of this proposal and a meeting between the lead researcher and



my lead supervisor, the MEMOS proposal was resubmitted to the Home Office complete with amendments to cover my involvement in the project.

The project was subsequently approved by the Home Office, and the new angle available to me through collaboration with MEMOS became central to my PhD. To formalise the arrangement I was given an honorary contract with Imperial College, a small expenses pot was made available, and I agreed to provide regular updates and a report of my findings to the DSPD Programme. Because the MEMOS team works closely with the 'Inclusion for DSPD: Evaluation, Assessment and Treatment' (IDEA) study run by the Department of Psychiatry at Oxford University, I was also issued with an honorary contract with their research team.

These developments, following from the DSPD Programme steer away from a study of DSPD policy decision-making, demonstrate that in order to negotiate access to prisons, researchers must be flexible in making the most of their opportunities, and prepared to develop a number of reciprocal relationships (King, 2000). The collaboration also suggests that there 'seems now to be some official recognition that PhD ... students may provide a useful – and cheap, if not free – resource to undertake exploratory studies of various issues' (King, 2000:290).

Although some may consider this collaboration to be indicative of the relationship between researchers and the Home Office as being 'far from symmetrical', with the real gatekeeping and funding power 'resting largely in the hands of officialdom'; developing a working relationship with government does not mean that 'one automatically buys in to an official agenda' (King, 2000:288-9). Moreover, 'the sociologist concerned with imprisonment can never rest entirely content with a singular role', and it is possible to deliver policy-relevant research and embark on a journey of theoretical development (Sparks et al, 1996). Although the relationship between the Home Office and

researchers has at times been problematic, 'fruitful collaborations' have also been developed (King, 2000). This was certainly one such collaboration and one I welcomed, not least because it enabled me to gain a greater proximity to, and understanding of DSPD, than I had previously envisaged.

Once the contracts were agreed, I set about trying to secure ethical and security clearance for the study. Despite the best efforts of the DSPD programme and the units to speed the process up, this took some considerable time, and was complicated by my involvement with a national study across establishments in the NHS and the Prison Service. In terms of security clearance I was subject to a Counter Terrorism Check (CTC), two enhanced Criminal Records Bureau (CRB) checks, and individual security checks at each of the four DSPD units. In order to gain ethical clearance, the study was approved by two NHS Central Office for Research Ethics Committees (CORECs)<sup>29</sup>, West London Mental Health NHS Trust, Nottinghamshire Mental Health NHS Trust, the Ministry of Justice, the Centre for Criminological Research at Keele University, and the Research Ethics Committee for the Faculty of Humanities and Social Sciences at Keele University. To satisfy the prison based sites, the MEMOS study was also signed off by the Home Office Project Quality Assurance Board (PQAB).

Once all the necessary ethical and security checks were underway, the lead researcher and I arranged introductory meetings and presentations at each of the units. These meetings with staff and prisoners/patients have been described as essential to the whole endeavour (Drake, 1997) because it is important that researchers engage in a period of informal familiarisation to develop trust, credibility and access (Sparks et al, 1996).

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<sup>29</sup> Now the NHS National Research Ethics Service (NRES)

Before data collection could begin, I was required to complete a staff induction at each of the four DSPD sites. The inductions varied in length from one to three weeks, and in total I spent nine weeks on inductions. I was required to attend a range of training sessions about: security; the use and management of keys; diversity awareness; institutional policies; health and safety; fire safety; first aid; breakaway; the management of violence and aggression; hostage-taking; first on scene; and the preservation of evidence. Once the inductions were complete, I was issued with identification cards, keys and a desk in each of the DSPD units.

As I completed the inductions for each site, I set about ensuring that I had prisoner and patient consent to view their files. Consent from DSPD patients and prisoners was sought on my behalf by on-site researchers from the IDEA team (see Appendix B for consent forms). This was mainly for operational reasons and our awareness that, in high security prisons, researchers must be sensitive to security and resource issues (Martin, 2000). Because it was proposed that our samples should be the same (to permit later collaboration), and as a result of several of the units operating a strict two-to-one policy with the patients and prisoners, this helped avoid duplication of effort, and reduce our demands on DSPD staff.

Forty-six patients and sixty-six prisoners consented to the amended participant sheet by the 28<sup>th</sup> September 2007, the end of the recruitment period for my PhD<sup>30</sup>. It is of note that patients and prisoners were only invited to consent to the study following formal admission to the assessment phase on the DSPD unit. It is regrettable that time did not permit interviews to be conducted with the patients and prisoners about their experience of PB and MHRT reviews, but the strict two-to-one policy with DSPD patients and prisoners would have left me reliant on considerable staff time to help

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<sup>30</sup> This date was originally chosen because it marked the end of my second year of my PhD, and time to draw a close to data collection. After this date I spent until December 2007 following up the participants who had consented to the study.

arrange and conduct the interviews. This demonstrates that 'interviewing detained patients raises difficulties over and above those ordinarily entailed' (Peay, 1989:37).

After formally accessing the DSPD units, I then turned my attention to negotiating access with the PB and MHRT Service to interview members about their experience of reviews with DSPD participants. Following several meetings with the MHRT Service and the Regional Chairman for the South of England, I achieved support to interview MHRT members and it was agreed that I could also collect data directly from the MHRT Service. Before interviews could commence, another bit of clearance was discovered, and I had to apply to the Ministry of Justice research unit for a Privileged Access Agreement (PAA) for permission to interview judicial members.

Initial meetings with the PB also went well and, on their advice, I made contact with the Public Protection Unit (PPU)<sup>31</sup> in the Ministry of Justice (MoJ), who agreed that I could access PB files from them. While provisional access to interview PB members was agreed, formal agreement was more difficult to establish. In hindsight this was unsurprising given the pressures on the PB at the time, which included a dramatic increase in caseload, the aftermath of two high profile inquiries into PB decisions to release (HMIP, 2006a, 2006b), and a number of legal challenges surrounding the independence of the PB from the MoJ<sup>32</sup>. Before formal agreement to interview PB members could be negotiated much perseverance, and a little help from the DSPD Programme, was required. Once a working agreement was established, the PB worked hard to facilitate interviews with members and to provide access to decision letters. A good dialogue has been developed and I have provided regular updates about the progress and findings of my research to the PB.

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<sup>31</sup> Formerly known as the Lifer Review and Release Section (LRRS).

<sup>32</sup> See *R(Brooke) v Parole Board* [2007] EWHC 2036 (Admin) and *R(Brooke) v Parole Board* [2008] EWCA Civ 29 and others.

### Key research questions

Based on the uncertain context of DSPD I was interested to explore what impact placement in a DSPD unit may (or may not) have on PB and MHRT decision-making. In this sense, the research aimed to consider *what* decisions PB and MHRT made and to explore *why*, rather than *how* they made these decisions. During my fieldwork, it became apparent that PB and MHRT members conceive prisoners and patients as needing to undergo a journey through the criminal justice and/or mental health system before they are suitable to be considered for release. Along these journeys, many key decision-stages exist, including PB and MHRT reviews. At each of these decision-stages, participants are 'made up' (Hacking, 1986; McCallum, 2001) and 'made sense' of by report writers and decision-makers. In this regard, my theoretical journey was similar to Irwin's (1970:1) who notes that although his book *The Felon*:

began as a study of parole. Almost immediately the boundaries were extended to encompass the extended "career" of the felon. The reason for this expansion was not simply the meandering interest of the investigator. Rather, it became apparent ... that to understand this phase of the felon's life it would be necessary to examine earlier phases, because the felon's parole experiences are shaped for him to some extent by orientations he acquires in prison. Furthermore, his position in the prison world is related to his preprison life.

My interest with the journeys and pathways of DSPD patients and prisoners and the significance of their placement in DSPD for PB and MHRT decision-making led me to consider the following key questions:

- 1) What are the characteristics of the men detained in the four high security DSPD units? What journeys have they made prior to and following DSPD admission?

How do multi-disciplinary report writers present DSPD patients and prisoners (and the DSPD units) to the PB/MHRT?

- 2) What were the outcomes of PB/MHRT with DSPD participants? Does placement on a DSPD unit impact on PB/MHRT decision-making? What sense have PB/MHRT members made of DSPD?

**Data collection: exploring the journeys of DSPD participants and the outcomes of PB and MHRT reviews**

Researchers are often advised to use a number of methods and sources of data in their research. In the context of prison research, King (2000) suggests that it may be best to begin with observation and documentary analysis, and then conduct interviews to enable what one has seen and read to be subjected to questioning and fuller understanding. To this end, I spent twelve months collecting data and speaking to as many people as possible across the four high security DSPD units for men, the PPU, and the MHRT Service. This enabled me to develop a better understanding of the nature of the DSPD units and the significance of PB/MHRT reviews. After a year in the field I turned my attention to conducting interviews with twenty-three members of the PB and MHRT.

***Informal observation (and dialogue)***

While observation was not a formal research tool, it became hard to consider my data as independent of this. Before I was allowed to commence the study I was heavily security checked, given honorary contracts with a number of organisations, and required to engage with nine weeks of full time induction programmes. Once my inductions were over, I was given keys and a place to work, and like other staff, required to wear an alarm and, in some sites, carry basic resuscitation equipment. In

many respects, I considered myself as a member of 'responsible staff', before a researcher. This demonstrates that security staff usually impress upon newcomers that they are an 'extra pair of eyes and ears' (Martin, 2000:222) and that the security of the institution and the welfare of those inside, is a shared responsibility, irrespective of role.

My presence in a number of DSPD related sites inevitably impacted on the choices that I made about data collection, interpretation and analysis. On entering the field I needed to familiarise myself with the data. It is important to remember, that, at this stage in my career, I had never seen a confidential prisoner or patient file, and consequently, I was unaware of what data may be available, in what form, and where it would be held. My experience was similar to Taylor's (1987) in that, although I had:

some ideas about what I wanted to find ... my priorities changed as the people I met there taught me what to look for and said what they thought was important (Taylor, 1987:50, quoted in Patenaude, 2004:80S).

This indicates that 'if a research project is genuinely directed towards new knowledge then there are limits to the kind of foreknowledge that the researchers can have' (Sparks et al, 1996:343). Unsurprisingly it may 'have the feel of an exploratory foray' (Crawley and Sparks, 2005:349). The development of the thesis was informed by a number of informal conversations with patients, prisoners, and staff from the DSPD units, DSPD Programme, PB and MHRT. This illustrates that researchers in high security settings must develop factual and cultural knowledge, and while factual knowledge can be learnt by consulting official and academic texts, cultural knowledge is 'less readily available and learned more slowly through observation and listening while "inside"' (Byrne, 2005:228). This cultural knowledge has been crucial for making

sense of the DSPD units and the significance of DSPD for PB and MHRT decision-making.

Originally I had hoped that observation would constitute a much larger data source. I had proposed to observe PB and MHRT reviews as they occurred for DSPD participants, and then interview the three member panels after the review had concluded. As a result of the high number of delays and adjournments, along with the challenge of being unable to be in several places at once, in practice, the observation of PB and MHRT reviews was particularly difficult, and in the end I was only able to observe six PB and half of a MHRT review. After several months of unsuccessfully chasing reviews around the country, I stopped, and focused my attention on negotiating access to interview PB and MHRT members.

### ***Documents***

Although one hundred and twelve participants across the four DSPD units consented to the study, not all of these had experience of a PB or MHRT review since DSPD admission. For the purposes of my research a review was operationally defined as: one where the reports had been compiled by DSPD staff; one that had taken place while the participant was resident on a DSPD unit; and one that had concluded by 28 September 2007. For reasons of time, space, and the need to separate my thesis from my report to the DSPD programme, this thesis considers a total of fifty-nine participants with experience of eighty reviews, corresponding to thirty-five prisoners with fifty-two PB reviews and twenty-four patients with twenty-eight MHRT reviews<sup>33</sup>.

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<sup>33</sup> My research for the DSPD Programme considers one hundred and seventy-two patients and prisoners who had consented to the study by 31 December 2007, and their experience of PB and MHRT up until this date. Those without a review are also considered in order to explore the significance of the legal status of DSPD participants. The larger study also relies on additional interviews with the PB, and with clinical and progression leads across the four DSPD units, to explore the significance of PB and MHRT reviews from the perspective of DSPD unit staff.



Before information could be collected about PB and MHRT reviews I needed to establish who had had an eligible review. Initially, basic demographic information was collected about the full 112 sample, helping to generate a database with a number of key variables including date of birth, index offence, ethnicity, marital status, legal status (that is, the date, type and length of sentence or section), location prior to DSPD admission, parole eligibility or tariff expiry dates, and records of any PB/MHRT.

For those who had experience of a PB or MHRT review since DSPD admission, the most obvious place to start data collection was with the reports that must be submitted to the PB/MHRT in advance of a review, and the written reasons and decision provided by the PB/MHRT following a review.

Reports to the PB must be compiled within a 'dossier'<sup>34</sup>. In the case of life sentence prisoners, dossiers must include details of the offender, their index offence, offence related papers (including Judges sentencing remarks and pre-sentence reports), and a summary of progress in prison. Reports must then be submitted by the following prison staff: lifer manager; wing/unit manager; personal officer; seconded probation officer; home probation officer; general practitioner; and activity supervisor. Where available, an OASys<sup>35</sup> report and up-to-date Life Sentence Plan (LSP) should also be submitted. Other staff with specialist knowledge of the prisoner including chaplains and specialist staff should also submit reports, as should psychologists if 'there has been substantive psychological input into the case', and psychiatrists if 'there are mental health issues on which to report' (PSO 4700, Chapter 5).

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<sup>34</sup> Guidance for the contents of a PB dossier (at the time of the study) is outlined in PSO 6000 Parole, release and recall, PSO 4700 Lifer Manual, and the Parole Board Rules 2004. For reasons of space, and because only two of the prisoners had a determinate sentence, the guidance for determinate prisoners is not described here. It is important to note that in April 2009 chapters 5 and 6 of the PSO 4700 were replaced by PSO 6010 Generic Parole Process, and in August 2009 PSO 4700 was renamed as the Indeterminate Sentence Manual.

<sup>35</sup> OASys refers to the Offender Assessment System, a risk and needs assessment system which is used by the probation and prison service. It works by analysing offending history, social, economic and personal factors to predict the likelihood of an offender being reconvicted.

Prior to the MHA 2007, and under the MHA 1983 and MHRT Rules 1996 the MHRT must be provided with: a statement from the Responsible Authority (RA); an up-to-date medical report by the psychiatrist in charge of the patient's care, the Responsible Medical Officer (RMO); an up-to-date social circumstances report by an Approved Social Worker (ASW); a local facilities report, most often written by a social worker in the community; and in the case of restricted patients, a statement from the Secretary of State<sup>36</sup>. Many other reports are often submitted to the MHRT and, in the case of DSPD patients, these included addendum reports (following adjournments and delays), Care Programme Approach (CPA) reports, DSPD assessment or treatment reports, independent reports from psychiatrists and psychologists, correspondence from services in medium security, and articles from academic journals.

Basic demographic data about DSPD patients and prisoners were collected from a number of hard copy and electronic sources. In the prison service, these included hard copy OASys documents, probation and psychology files, and a database called the Local Inmate Database System (LIDS). In the mental health system, demographic data were collected from multi-disciplinary ward files and a database called RiO<sup>37</sup>. The PB dossiers and decision letters were accessed from the custody office of the prison and the PPU in the MoJ, while the MHRT reports and decision outcomes were collected from the MHA office of the hospital and the MHRT Service. Data regarding the process and outcome of PB and MHRT reviews were collected in considerable detail. Copies were made of the majority of reports submitted to the PB/MHRT and *all* of the PB/MHRT decision letters.

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<sup>36</sup> See the MHRT Rules 1996, Home Office (2004) and Ministry of Justice (2007a) MHRT guidance for more information.

<sup>37</sup> RiO is an electronic care records system produced by CSE Healthcare Systems (see <http://www.cse-healthcare.com/RiO/index.html>). Access to LIDS and RiO requires a password for access, and although I eventually secured access to these in some sites, access to these databases was usually facilitated by staff.

Reports and outcome letters were either typed onto a laptop computer or photocopied. Photocopies were anonymised on-site and then re-photocopied before being scanned into a text document using an OCR (optical character recognition) scanner. This generated electronic copies of the data that could then be imported into a qualitative software package for analysis. Access to photocopy records largely depended on the trust and policies of staff at each data collection location. As time went on, and more trust had been developed, the majority of locations would allow me to photocopy what I needed<sup>38</sup>.

Documents are a rich source of data because they are naturalistic, not affected by the presence of a researcher, do not flood the data with researcher categories, and may uncover unknown issues (Hepburn and Potter, 2004; Silverman, 2001). Documents can also be particularly helpful for providing 'access to events that cannot be observed' (Miller and Alvarado, 2005:353) or insights that cannot be accessed through interviews (Hawkins, 2002).

Qualitative researchers are interested in the socially constructed nature of documents and seek to examine how they represent and organise reality (Atkinson and Coffey, 2004; Brookman, 1999; Prior, 2003; Silverman, 2001). Files 'are not simple 'records' of events, but are 'manufactured' (Prior, 2004) and 'artfully constructed with a view to how they may be read' (Silverman, 2001:131). It is for this reason that:

qualitative researchers are not primarily concerned with whether files are factually 'true' or 'false'. Instead they focus on how such files reveal the

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<sup>38</sup> It was strange that staff were happy for me to access the reports and type them up in full, yet anxious about me taking photocopies. It may have been that staff felt safer to allow me to take my own copy in an anonymised text document because institutional identifiers like familiar report formats and Prison Service logos were absent. The content of the data might be the same, but it would not look the same. As a result its significance may be less obvious to outsiders, and would be easier to dismiss if the analysis generated unwelcome findings.

practical decision-making of employees in the context of constraints and contingencies of their work (Silverman, 2001:133).

Records of legal proceedings 'constitute a potential goldmine for sociological investigation' because they are often accessible and help reveal how 'agencies account for, and legitimate their activities' (Silverman, 2001:135; see also Burton and Carlen, 1979; Hawkins, 2002). In this way, they are a useful method of examining organisational discourses, and can:

provide valuable data for the analysis of official definitions of what is defined as problematic, what is viewed as the explanation of the problem, and what is deemed to be the preferred solution (Jupp, 2006:276).

This reminds us that documents cannot be divorced from the intention of the authors (Scott, 1990 in Brookman, 1999), and that official documents are written for a specific purpose and audience (Brookman, 1999, Padfield, 2002). In the context of reports submitted to PB, 'material is likely to be organised in such a way that the case is "constructed" according to the Prison Service's perspective' (Padfield, 2002:85). This is important because PB reports may be attributed a significance they do not possess, fail to tell 'the whole story', and 'provide a grimmer picture of a prisoner than other sources' (Padfield and Liebling, 2000a:83).

For this reason, it is crucial to emphasise that the institutional responses of DSPD patients and prisoners described in this thesis are presented from the accounts of DSPD staff<sup>39</sup>. By relying on prison records 'we must see inmates through the eyes of

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<sup>39</sup> A small number of studies have considered the perspective of DSPD patients and prisoners, but samples have often been small and limited to one site (see Crewes, 2006; Maltman et al, 2008; Tyrer et al, 2007; Whittle, 2005).

staff' (Toch and Adams, 2002:18), and as a consequence the presentation of different prisoner and patient careers are 'impressionistic' (Cohen and Taylor, 1972). There are limitations to this approach. Comparison between the DSPD patients and prisoners has been difficult because of the different sources of information, and it is important to acknowledge that the reliance on staff reports (rather than patient and prisoner accounts) may lead, incorrectly, to DSPD participants being presented as a passive group with little agency.

### **Interviews**

The analysis of PB and MHRT documents could, of course, only take me so far in developing an understanding of the significance of PB/MHRT reviews with DSPD patients and prisoners, and for this reason a number of interviews were completed with PB and MHRT members. Qualitative interviews often take the form of a 'conversation with a purpose' (Burgess, 1984:102), in that they seek to 'understand the world from the subjects' point of view [and] to unfold the meaning of people's experiences' (Kvale, 1996:1). Two contrasting metaphors of the interview are suggested by Kvale (1996:3-4) – the miner, who considers knowledge to be given, and capable of being unearthed, and the traveller, who acknowledges that knowledge is generated by the process of conversation and interaction between the researcher and the persons which s/he seeks to study. My approach most closely corresponds with Kvale's (1996) traveller metaphor, which is best described in his words:

[the] *traveller metaphor* understands the interviewer as a traveller on a journey that leads to a tale to be told upon returning home. The interviewer-traveller wanders through the landscape and enters into conversations with the people encountered. The traveller explores the many domains of the country, as unknown territory or with maps, roaming freely around the territory. The traveller

may also deliberately seek specific sites or topics ... the journey may not only lead to new knowledge; the traveller may change as well (Kvale, 1996:3-4).

Twenty-three semi-structured interviews with PB and MHRT members were conducted. Following twelve months of data collection and growing awareness of relevant empirical, theoretical and methodological literature, two interview schedules were devised (see Appendixes C and D). It was agreed with the MHRT Service, the MHRT Regional Chairmen and the MoJ Research Unit that interviews with MHRT members could take a case study focus. In contrast, a condition of access to interview PB members was that individual cases would not be discussed. As a result interviews with MHRT members tended to be more unstructured. This aside, the main interest of the interviews was to explore how placement in a DSPD unit may (or may not) impact on the deliberations and decisions reached by PB and MHRT panels. Several key themes were explored including: members' experience of DSPD hearings; the significance of the information provided by the DSPD unit; (dangerous and severe) personality disorder; dangerousness and risk assessment; participation with treatment; and progression.

Only a small proportion of the larger PB and MHRT membership is likely to have had experience of a PB or MHRT review with a DSPD patient or prisoner. Members with relevant experience were identified by the PB and the MHRT Service from a list of the fifty-nine participants and their eighty reviews. My intention was to interview between nine and twelve members from each service and to ensure that the views of different types of member were captured. The composition of PB and MHRT panels is discussed further in chapters seven and eight, but three-member PB and MHRT panels with DSPD prisoners and patients usually include a legal, medical and independent/lay member.

Letters introducing the study, participant information sheets and supporting letters from the Chief Executive of the PB, and the Regional Chairmen of the MHRT (see Appendixes C and D) were emailed or posted to forty-four PB and forty-six MHRT members. The forty-four PB members, consisted of twenty independent, twelve judicial, nine psychiatrist, two psychologist and one probation member. Of these, five independent, four judicial, one psychiatrist and one probation member gave their consent to an interview. Of the forty-six MHRT members who were contacted, sixteen were legal members, fifteen medical, and fifteen lay, of which three legal, two medical and seven lay members consented to the study. It is of note that the response rates between the different types of PB and MHRT members were similar in that psychiatrists were least likely to respond, while lay/independent members were more likely to respond.

A total of twenty-three interviews lasting between thirty and sixty minutes, were conducted. The majority were conducted over the telephone, according to the preference of the member, although several were conducted face-to-face. While telephone interviews are often viewed as inferior to face-to-face interviews, the evidence that they produce lower quality data is lacking (Novick, 2008, Sturges and Hanrahan, 2004). Research has found that they are an appropriate method for interviewing experts (Opdenakker, 2006), and although the absence of non-verbal communication and social cues is thought to be problematic, some have found that telephone interviews can enable respondents to feel more relaxed and able to disclose sensitive information (Novick, 2008).

Audio recordings were made of all but two interviews, where, in one case, the interviewee asked that I didn't record the interview, and in the other, following a problem with my recording equipment. The audio recordings were sent to a private company for transcription. Although this meant that I had less opportunity to familiarise

myself with the interviews, on receipt of the transcripts, I made sure to check them against the audio, enabling me to properly anonymise them, amend the DSPD jargon that had been unfamiliar to the transcriber, and to re-familiarise myself with what had been discussed.

### **Data analysis: making sense of the journeys of DSPD participants and the outcomes of PB and MHRT reviews**

The data were analysed in light of the theoretical framework that developed through the process of data collection and analysis. Theoretically, the thesis is structured around the notion that prisoners and patients undergo a journey while in detention and along this journey key decision-stages exist, including PB and MHRT reviews. At each of these stages, DSPD patients and prisoners are ‘made up’ (Hacking, 1986; McCallum, 2001) and ‘made sense of’ by DSPD report writers and PB and MHRT decision-makers.

As I collected data and continued to engage with the theoretical literature, the data were coded. Coding in qualitative analysis involves organising the data and the identification of conceptual categories in line with developing thematic interest (Noaks and Wincup, 2004) and helps to provide an important link between data and conceptualisation (Bryman and Burgess, 1994). This reminds us that qualitative research involves a ‘constant interplay’ of data collection and analysis (Wiseman, 1974:317 in Bryman and Burgess, 1994) and that ‘both empirical research and “theorising” must go hand in hand’ (Layder, 2006:1; see also Brown and Lloyd, 2001; Cresswell, 2007).

NVivo, a computer assisted qualitative software package developed by QSR, was used to help with the task of analysis. Using NVivo, I generated ‘procedural codes’ to help



organise the data and 'theoretical codes' to help make sense of the data. This highlights that qualitative analysis involves two key stages: managing the data; and 'making sense of the evidence through descriptive or explanatory accounts' (Ritchie et al, 2003:219). Research has identified that a combination of manual and computer assisted software may generate a better analysis (Welsh, 2002) and while NVivo was helpful for organising the data, I also spent considerable time re-reading and hand coding hard copies of data to ensure an in-depth analysis. This reminds us that NVivo does not replace the need for close analysis (Fisher, 1997) and that constant 'familiarisation' with the data is a crucial part of qualitative analysis (Ritchie et al, 2003).

The findings of my thesis are presented across four data chapters. The first two data chapters (five and six) explore how the journeys of patients and prisoners before and after DSPD admission are presented by DSPD report writers, to the PB and MHRT. The participant's career was considered to have three significant stages: prior to conviction for the index offence; prior to DSPD admission; and following admission to DSPD. In order to explore these stages, chronological timelines were developed which documented key events of interest including date of sentence, institutional moves (and reasons), adjudications, completion of treatment programmes, transfer in (and out) DSPD units, tariff expiry dates, and PB or MHRT reviews (and outcomes). Alongside this, more detailed summaries were prepared for each participant detailing how the report writers described them at each stage of their journey through the criminal justice and/or mental health system into DSPD.

The two chapters that follow (seven and eight) explore the significance of DSPD for PB and MHRT decision-making. Drawing from analysis of the outcome letters and interviews with PB and MHRT members, the chapter reveals the outcomes of PB and MHRT reviews with DSPD participants, and explores the significance of any commendations, suggestions and recommendations, made by the PB and MHRT. The

chapters also seek to 'tell the story' from the point of view of PB and MHRT members, and consider what sense external decision-makers like PB and MHRT members have made of the DSPD programme, and how this may have impacted on the decisions that they made.

### **Some challenges along my research journey**

Having provided a sanitised account of my research journey, I now turn to consider some of the challenges I encountered along the way. My use of the term sanitised indicates that while I wish to explore some of the challenges I experienced, I also want to avoid presenting a 'heroic tale'. High security facilities are notoriously difficult to gain access to for good reason. They can also be demanding places to conduct research, because they are not intended to be easy to navigate. Information is difficult to locate for a reason. Knowledge is quite understandably guarded and access only granted on a need-to-know basis. My use of the term sanitised also follows from the difficulties involved with presenting an honest account of conducting research in high security settings. What goes on inside prisons and high security hospitals is largely unknown for good reason, and it is important as a researcher, that I do not break the security and trust afforded to me by the institutions, the staff, and the patients and prisoners inside.

### ***Gaining access to the field***

The nature and location of prisons means that few criminologists are able to gain access and study them, and if they are, their credibility and integrity is constantly tested, as they attempt to gain access, establish rapport and trust, and provide feedback and publication (Paternaude, 2004:72S). This closely reflects my research experience, and while I have suggested that research is often dependent on a number of fortunate events, opportunities are unlikely to materialise without a proactive and determined effort from the researcher.

Naïvely, I assumed that once I had been issued with ID and keys for each of the four DSPD units, that I was 'in' and that issues of access had been largely resolved. Yet, access to view hard copy and electronic files, bring a laptop and digital recorder in, still had to be negotiated. I quickly learnt that even following external approval, access negotiations continue on 'almost a daily basis' (King, 2000:297), and that access agreement at management level, did not necessarily carry the desired weight when trying to access information from staff on the front line. This demonstrates the 'realities of multiple gateways' governed by informal and formal gatekeepers with different interests, understanding of research, security concerns and suspicions of external researchers (Byrne, 2005:226, see also Brookman, 1999; Martin, 2000; Roberts and Indermaur, 2008; Smith and Wincup, 2000).

Developing trust with a number of different gatekeepers and participants is crucial to the success of research in high security settings, yet difficult to establish (Roberts and Indermaur, 2008). Both prisoners (Hare, 1983) and staff often share a distrust of external researchers (Patenaude, 2004). In order to gain the trust of participants, researchers need to present themselves as competent but also keen to learn from the experts (Brookman, 1999). In order to achieve this, researchers must provide 'proof that they have some basic knowledge about their respective situations and respects them as individuals' (Patenaude, 2004:79S).

One of the ongoing challenges I faced was the problem raised by staff turnover. Personnel changes are not uncommon in prisons, but can be problematic for researchers because they generate the need for another round of explanatory meetings (Byrne, 2005). Along with the challenges raised by staff turnover, I also struggled to keep a hold of the participants, as patients and prisoners transferred in and out of the units. Added to this was the high incidence of name change amongst the patients. Previous research has found that seventeen percent of patients in one high

security hospital changed their name, and that this was more common amongst those with a diagnosis of personality disorder (Vollm et al, 2002). These observations highlight some of the challenges involved with trying to capture certain truths about institutions that are constantly changing (Genders and Players, 1995). To help manage these challenges I made sure to establish a number of key contacts at each site, whose support was invaluable.

Other successful, but simple methods of negotiating access within the field involved carrying evidence of my clearance, along with a regular supply of biscuits. I soon worked out that biscuits were a very good method of getting what I wanted. This highlights that access to sensitive case files often ‘appear to owe very little to the value of the research, and more to serendipity, determination and good negotiation skills’ (Brookman, 1999:48)<sup>40</sup>.

While negotiating access is one of the ‘greatest challenges’ of research in high security settings (Patenaude, 2004:72S), by the end of my fieldwork I was largely free to roam where I wanted and access whatever files I wanted. People stopped asking me what I was doing, and left me to get on with it. In a similar way to Liebling (1999:155), I found myself, particularly with the benefit of hindsight, ‘amazed (and disconcerted) by the easy trust’ I was offered and the level of access I had been able to achieve.

### ***Getting on and fitting in with the field***

Prisons are largely structured around routines (Byrne, 2005; Cowburn, 2007; Drake, 1997) and ‘research has to fit in with whatever else is going on’ (Martin, 2000:221). Ethically, it is important that researchers are ‘sympathetic to the constraints on organisations participating in research and [do not] inhibit their functioning by imposing

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<sup>40</sup> Although this method of access negotiation was very successful during the data collection for my PhD, on recent return to the field, I have discovered that I am remembered as the ‘nice lady who brings biscuits’ rather than for my ability as a researcher!

any unnecessary burdens on them' (British Society of Criminology, 2006). Where at all possible I tried to minimise my demands on staff. One consequence of this is that data collection took far longer to complete than envisaged. As a result of operational issues including schedules, security threats, and/or lock-downs, research can be easily 'inhibited, delayed or cancelled' (Paternaude, 2004). This reminds us of the importance of 'time' in prison and that it is:

marked out in particular ways both in terms of the long duration of a career or a sentence but in the division of daily time by routines, shifts and events. Researchers need to understand these features of time and their activities must in a sense mirror its 'flow' (Sparks et al, 1996:350).

Security concerns are unsurprisingly high on the agenda in high security settings (Byrne, 2005), and it is important that researchers comply and fit in with the regime as best as possible (Genders and Player, 1995). I was very aware that my access to these sites and, in particular, my status as a key holder, was a privileged position to hold, and one I took seriously, not least because it is 'imperative that the researcher be mindful that he or she is a guest in the facility where policies, rules, and regulations are usually rigid for everyone's protection' (Drake, 1997:43).

The appropriate use of language is also an important aspect of developing rapport and getting on in the field (Paternaude, 2004), especially in prisons where the 'language and conventions are almost wholly unfamiliar' (Sparks et al, 1996:340). Not only was I required to learn the unofficial language of the inside but, as I moved between the hospital and prison sites, I had to be careful. When in the mental health system, individuals are patients not prisoners, they may sometimes be secluded rather than segregated and, if they are to leave the setting, they are discharged rather than released. While in the prison system, it was more appropriate to use the latter terms.

To use the wrong language in the wrong place may have left me open to being perceived as too punitive and insensitive in the health system, and too liberal and naive in the prison environment. This reminds us of the importance of language for providing a map of the institution, and that 'there is an argot to be mastered and a misused term marks you off as a pretender' (Sykes, 1958:xix).

### ***Quality and availability of data***

Although on the whole everyone in the units was helpful and co-operative it was certainly a challenge to try and establish a basic dataset on one hundred and twelve patients and prisoners, and to obtain all of the documents submitted to the PB and MHRT. I found that the quality and availability of data varied enormously. When data were available they were not necessarily easy to access and often I found that files were scattered across a number of locations. This meant chasing up files that were buried underneath the paperwork of a member of staff's desk or requesting that files be ordered in from external archives.

This demonstrates that file analysis can be notoriously difficult because records are often incomplete and constructed for reasons other than research (Garfinkel, 1967). On many occasions data were unavailable, incorrect, or contradictory. This highlights that the quality of data in the Prison Service is not always how researchers would like to find it (Padfield, 2002) and that thousands of LIDS records have been identified as either wrong or incomplete (Collins, 2008).

Although the inconsistency and diverse locations of data were frustrating, there were some advantages to my struggles. By having to cross-check the information across the files, the likelihood of it being correct was increased. Moreover, some of the challenges that I experienced with documentary collection are relevant to the findings of the study, as report writers must draw from the same sources that I was using. Like

the researcher, prison and hospital staff may also struggle to know and present a full picture of DSPD patients and prisoners when they write reports.

### ***Researching decision-making after the event***

Decision-making is inherently difficult to research because it is elusive and often inaccessible (Hawkins, 2002; Peay, 1989). We only know a decision has been made after the event, and how people talk about the decision after the event may not accurately reflect the processes that occurred at the time (Manning, 1996 in Hawkins, 2002; see also Peay, 1989). This indicates the difficulty of distinguishing 'a feature that has prompted a particular decision outcome from one that is employed after the event as a justification for a decision' (Hawkins, 2002:448). It is important to acknowledge in regard to my interviews with PB and MHRT members, that interviews are a reconstruction of events, and:

there is a tendency for officials to serve as carriers for the organisation's public ideologies ... and it is sometimes difficult to know when the 'real' as opposed to the 'official line' is being put forward (Hawkins, 2002:449).

These observations highlight that because decision-making is complex and 'subject to a series of influences which interact simultaneously' (Peay, 1989:22), different research methods can only provide a partial picture. For this reason, a combination of methods should be used to research decision-making (Hawkins, 2002; Peay, 1989).

### ***Managing my self presentation and the interpretation of others***

As a young female PhD student, with limited research experience, it is important to consider how my background may have influenced my access, data collection, and interpretation. Many researchers have considered the gender, age and background of prison researchers to impact on the interaction with, and confidence of, prisoners and

staff (Crawley, 2004; Gelsthorpe, 1990; Genders and Player, 1995; Liebling, 1999; Morris et al, 1963; Scully, 1990; Smith and Wincup, 2000). These factors, and the researcher's 'impression management' (Goffman, 1969) ability are important for gaining the trust and co-operation of gatekeepers and research participants.

The researcher identity and their real and perceived relationship with authority are important in prisons research (King, 2000). Although PhD research is probably regarded as less threatening than other research, because it is often small-scale and can be dismissed if it generates unwelcome findings (King, 2000), I rarely presented myself as just a 'student'. Instead, I used my affiliation with others to help establish my credibility within the units, the PB and the MHRT Service. This often worked to good effect, highlighting that 'who you know' is a crucial factor in opening doors (Brookman, 1999), and that staff involved with Home Office commissioned research, often gain high levels of co-operation in terms of carrying keys, accessing prison files and securing help from senior staff if the researcher encounters problems (Martin, 2000).

My involvement with research that had been commissioned by the DSPD programme, however, did not always achieve the desired result, highlighting that 'institutional connections are ... deeply double edged' (Sparks et al, 1996) and 'perceptions of the research team as a sincere and neutral party (or at least nonaligned) are essential' (Patenaude, 2004:80S). Unsurprisingly, some DSPD staff, PB and MHRT members were 'naturally curious' about the nature of my relationship with the Home Office (Smith and Wincup, 2000:340) and questioned the extent to which the research was truly independent.

On one occasion, a senior Judge, with strong views about the focus of my study, observed that while he was very pleased that my area of research was being considered, he nevertheless (albeit tactfully) explained that he was disappointed that it



was not being carried out by somebody more senior. He also presented as sceptical about the true independence of the research. Before he would agree to an interview, we had a number of challenging conversations over the phone and via letter. It was clear that he was trying to find out more about me and, as a result of his own views about the study, determined to find out where my allegiances lay, and to ensure that my analysis was sympathetic to his viewpoint. I found myself having to navigate a difficult balance of trying to gain the participant's trust, while also staying as neutral as possible in regard to my opinions about the issues under study.

This reminds us of the 'hierarchies of credibility' and the importance of 'whose side are we on?' (Becker, 1967). This has been considered by several researchers in the context of prison research (Liebling, 1992, 2001; Smith and Wincup, 2000; Piacentini, 2007; Sparks, 2002; Wacquant, 2002) but has tended to focus on the conception of two sides: the prisoners' and the staff's. In my experience, I found myself balancing (and being perceived as taking) a number of different sides ranging from that of the patients and prisoners, the DSPD unit staff, the DSPD Programme, and the PB and MHRT.

On re-reading Catrin Smith's account of her doctoral research in three womens' prisons in the mid 1990s (see Smith and Wincup, 2000 for a discussion), I was surprised to note the similarities in our research experiences. Having negotiated what she describes as an 'informal *quid pro quo* relationship with the Prison Service Directorate of Health Care', a relationship that appeared similar to my own with the DSPD programme, she recalls having experienced a range of social responses in the field, 'from the generally paternalistic (young female researcher needing help) to the overtly flirtatious', leading her to ask: 'whether or not researchers can flirt (maintaining access), whilst also holding on to a sense of integrity' (Smith and Wincup, 2000:339).

This is an important question, and although, in the main I did not experience many situations of 'overtly flirtatious' interaction, this was a question that I had to ask myself during access to one fieldwork site. Although I was able to secure agreement to everything I wanted, the over-familiarity of my gatekeeper caused me concern on a number of occasions. While, in the end, I was happy that no boundaries were crossed, at the time I was very conscious that if I was to (over?)react to his approach, I was at risk of losing all co-operation and chance of access.

It was striking, however, how many staff adopted a paternal (and maternal) approach in that they were keen to protect me from 'tripping up' but also supportive in enabling me to 'stand on my own two feet'. In the early stages of my fieldwork, one staff member was keen to remind me that I needed to keep a 'check' on how I was dealing with the nature of the information that I was collecting, reminding me that 'we are all human'. At another site, several staff were keen to warn me away from a particular prisoner whose sexually inappropriate behaviour towards female staff was causing concern. On other occasions, a number of staff expressed concern about where I was staying and for my personal safety when leaving the units in the evening.

While I did not consider my age and gender to generate many problems, on some occasions it presented more difficulties. Young females are often assumed to be particularly vulnerable and susceptible to manipulation by men with personality disorder, and the belief that young female staff constitute an additional risk in the institution because of their perceived vulnerability to assault and hostage taking (Genders and Player, 1995) structured a few of my experiences as a researcher. During one induction, the male security staff, strongly emphasised to me and another female researcher of a similar age, that it is very easy to 'fall in love' with patients with personality disorder, and advised us to be particularly careful and aware of our interactions. Seated within a group of over fifteen new members of staff, it was clear

that this warning was not delivered with the same emphasis to other male and older female members of the group.

Other individuals with whom I negotiated access treated me with more suspicion. On several occasions, I experienced some interrogation of the reasons behind my interest in DSPD. Surely I must be a journalist, a Home Office spy, guilty of voyeurism, or just a little strange. What made a young female choose to research men identified as needing DSPD treatment? This highlights that, as a 'stranger' in the prison, researchers can expect to be treated with suspicion and curiosity and be 'recast in a number of different roles' (Smith and Wincup, 2000:340; see also Sparks et al, 1996). It also demonstrates that as a stranger, my characteristics led to occasional concerns, that my presence in the field may generate a number of risky situations. These included the risk of falling in love with or being taken hostage by a DSPD participant, delivering an ill-informed research study, or simply leaving the field and selling my story to the media.

### ***Managing the emotional challenges of high security research***

Dispersal prisons can be difficult and emotionally complex places to work, with the ability to generate the most 'acute experiences' and have a 'dramatic impact' on researchers (Liebling, 2004:152-153). The emotional challenges brought about by working with difficult participants and the large number of 'procedural hoops' have deterred many researchers from conducting research in prisons (Patenaude, 2004).

During my fieldwork my working and personal life was heavily disrupted, as it became scattered across the back-seat of my car, budget accommodation, and a number of fieldwork sites. This demonstrates that while research in high security settings can be rewarding, it can also be an isolating experience (King, 2000; Smith and Wincup, 2000). The isolation of researchers from their 'normal' lives is likely to be heightened if they do not have any clinical input into the treatment community which they study

(Menzies and Lees, 2004). It is easy to find oneself in a situation, similar to that described by Liebling (1999:160):

We lived, albeit temporarily, in circumstances reminiscent of the prison experience – without easy access to telephones, away from our friends, cut off from our lives and propelled into others' worlds, with all the consequences staff reported to us of prolonged detached duty.

In response to these challenges of spending long periods within the prison field, Liebling (1999:150) recalls how 'it was tempting to drink and smoke more than usual, listen to extra loud music, drive too fast and resort to other stress-related behaviours'. Similarly, I found that as my mileage shot up, so too did my speedometer, the volume of my music, and a number of ill-informed lifestyle choices. Despite these reactions, spending time in the field is crucial to prison research (Liebling, 1999; King, 2000, Smith and Wincup, 2000; Sparks et al, 1996). Moreover, the 'capacity to feel, relate, and become "involved"' are important skills that researchers must adopt as they become 'affectively' as well as physically present in the social context in which their research is based (Liebling, 2001:474). Crawley (2004:47) argues that 'feelings become a commodity for achieving instrumental goals'. Providing the researcher does not 'go native', become over-involved, or breach boundaries, the more affective the research, and the better fieldwork is completed (Liebling, 2001).

Over a twelve month period I collected the life stories of DSPD patients and prisoners, as presented by the reports submitted to the PB and MHRT. As one may expect, these files outline in considerable detail, the backgrounds, index offence, attitudes and fantasies exhibited by the offender, and their responses to the institutional environment. While prison researchers must maintain a professional approach at all times and 'by choosing to enter the prison gates the researcher must leave his/her

personal prejudices behind' (Martin, 2000:231), researchers nevertheless may have to manage negative feelings about their participants, and these 'feelings and expectations not only affect the research, but become part of the process itself' (Kleinman, 1991:184).

This reminds us of the importance of emotions in research (Kleinman, 1991, Smith and Wincup, 2000) and that 'research in any human environment without a subjective feeling is almost impossible – particularly in a prison' (Liebling, 1999:147). Drawing from Hochschild's (1983:7) concept of 'emotional labour', that is, 'the management of feeling to create a publicly observable facial and bodily display', Crawley (2004) explores how prison officers manage their emotions in order to meet the requirements of the organisation. While it would be insensitive to compare my 'emotional labour' with that of front-line staff like those in Crawley's (2004) work, I was nevertheless required to adopt a 'specialised emotional stance' (Rhodes, 2004:27) in order to successfully manage the emotional challenges generated by my research.

There are numerous examples that I could give of the emotional challenges presented by my research, ranging from encounters with difficult staff and prisoners, to reading things in reports that I would rather not know, to more serious occurrences including being present on a DSPD unit when the death of a prisoner was discovered. To discuss many of these examples would compromise the confidentiality of patients, prisoners, staff and the institutions themselves. This demonstrates that researchers in high security settings must learn to manage the knowledge generated during the course of their research, and protect it in accordance with the values of the organisation.

One good (and non-sensitive) example of the emotional challenges I encountered, followed from the considerable time and energy I spent trying to observe MHRT

reviews. As a consequence of the high level of adjournments and withdrawals, in practice it was very difficult. On the morning of one review, I met with the patient who was pleasant, welcoming, and happy to consent for me to observe his review. During the first half of the review and before the Tribunal broke for lunch, the hospital psychiatrist was trying to provide evidence that the patient was treatable under the MHA 1983. Evidence of the patient's improvement, however, was sparse and the psychiatrist was relying mainly on the patient's recent admission of his offence. After a short lunch break, the patient was brought back up from the ward and the Tribunal reconvened. But something was wrong and, almost immediately, the patient became very agitated. His solicitor quickly requested to speak with the patient outside of the room; returning five minutes later, the solicitor asked that I leave.

As I left the Tribunal I was dealing with many emotions ranging from embarrassment to frustration. This was not helped by a dramatic shift in the patient's behaviour, as he turned on his chair and watched me walk out with an ear-to-ear smile. Outside I found a few staff, who like me, were unsure of why I had been asked to leave. Confused, tired, and frustrated, I left the hospital for the day. This was the ninth Tribunal that I had tried to observe, and I hadn't been able to see it through to its conclusion. It was time to get away from the field.

A few weeks later I returned to the hospital. Although the patient had withdrawn his consent for me to observe his MHRT, I needed to establish if he had also withdrawn from the larger study. Once I was satisfied that I still had the patient's consent to view his files I located the MHRT reports and outcome. The reasons for the MHRT noted the discussion about the patient's admission to his offence, but to my surprise, further identified:

The Tribunal was in possession of a document prepared by [the patient] ... This is a detailed document in which he says that he has admitted the offence, and that he will undertake any therapy that is required of him ... In evidence [the patient] indicated that he had been coerced into writing the document by a researcher from Oxford University (1018, MHRT decision).

Although I was not implicated in this 'coercion', I then understood that my status as a researcher and affiliation with the research team from Oxford University was a likely reason for the patient having asked me to leave his Tribunal. This experience highlights that researchers can not only easily find themselves in unforeseen and emotionally challenging situations, but that they can also have an impact on the field under study.

### ***Leaving and taking time out from the field***

The emotional challenges presented by conducting research in high security settings reveal the importance of knowing when to leave the field. Several scholars advise that researchers involved with research in prisons (Liebling, 2001; King, 2000) and therapeutic communities (Genders and Player, 1995; Morant and Warren, 2004) should allow themselves time out from the field. A process of withdrawal and reflection can help avoid burn-out and research fatigue, enhance the quality of the interpretation of the data, and facilitate a rigorous analysis (Genders and Player, 1995; Liebling, 2001).

Leaving the field however can be difficult (King, 2000; Smith and Wincup, 2000; Sparks et al, 1996). Although my year in the field had been emotionally and physically tiring, I had also found it incredibly rewarding and interesting. This reminds us that fieldwork emotions can be 'treasured sources of energy and insight' (Wolcott, 1995:67). Once I had left the field, I longed to return and struggled to adapt to my previous world, of driving a short distance, to the same place of work, every day of the week. Liebling (1999:161) describes a similar experience, in that although she and her research team

were 'relieved' once the fieldwork had concluded, they found the experience of returning to their own worlds as disturbing as they struggled with 'a sense of detachment and disorientation, and a frustration at wanting to share the experiences with others' but finding it impossible to relate. This demonstrates that one of the particular difficulties with leaving the prison field follows from the need to manage the knowledge gained from the inside. Although friends and family were interested in what I had seen, it was important that they did not know. My time in the field had made me particularly sensitive to the needs to maintain security, confidentiality and trust of those whom I had encountered during my research.

### ***Managing the ethical and political challenges of high security research***

There are numerous ethical challenges involved with conducting research with prisoners and patients. One obvious issue is the important one of gaining informed consent. DSPD prisoners and patients were approached on my behalf by on-site researchers from Oxford University with amended consent forms (that had been approved by the NHS COREC committee) (see Appendix B). The researchers explained the research study and gave patients and prisoners at least twenty-four hours to consider if they wished to take part. Participants were encouraged to ask any questions that they may have and reminded that they were welcome to withdraw from the study at any point. It is also important to note, in light of previous research that has identified that some prisoners believe they will be given credit by the PB for taking part in research (Drake, 1997), that participants were told explicitly that their participation (or non-participation) would have no impact on their PB or MHRT reviews. During the course of my research I often had the opportunity to meet with patients and prisoners, and on these occasions took the opportunity to reiterate the aims (and limitations) of the study, and answer any questions that patients and prisoners may have had.



The growing media interest that developed with cases of 'missing data', where sensitive data had either been lost or stolen, and with DSPD, heightened my anxieties about the confidentiality, anonymity, and security of my dataset. During my fieldwork, several challenges were raised by a tabloid newspaper and a social networking site developing a particular interest in DSPD. In March 2004 *The Sun* newspaper published an article headed up with 'You'd kill for this... A £14 million luxurious prison wing to house Britain's most evil criminals' (Perrie, 2004). Over the next few years a number of DSPD related articles emerged expressing concerns about the cost and facilities, the smoking ban, and that DSPD patients had been allowed to form a rock band. More worryingly, extracts of patient reports, artwork, and a digital recording of a patient band found their way onto the internet.

That the tabloid newspapers reported negatively on the DSPD units was unsurprising and, at first, unproblematic. Significantly, in regard to the study reported here, in June 2008, the front page of *The Sun* newspaper read: 'I'm a psycho rapist: why did Broadmoor let me out' (Flynn, 2008, see also Flynn and West, 2008, Pyatt, 2008, Wells, 2009). Less than a year later, under the heading of 'Broadmoor free beast' (Flynn, 2009), *The Sun* published an article about another patient, claiming that 'A VICIOUS sex fiend has been released from a Broadmoor unit reserved for its most twisted inmates - despite being branded "a grave danger to women"'.

By heightening my anxieties about the anonymity of participants, this media attention to the discharge of DSPD patients by MHRTs, had a significant impact on the choices I made about the analysis and presentation of my data. These headlines remind us that researchers must maintain a 'careful interface' with the media, because local and national newspapers are often interested in the nature of prison studies (Byrne, 2005) and that 'the information provided to researchers might be valuable in its raw form to all kinds of other people' (Israel, 2004:733). This highlights that in practice it can be

difficult to hide the identity of participants from their peers, investigative journalists and officials (Lowson, 1970 in Ellen, 1984) and that there are 'real dangers in investigating small, high-profile groups ... whose future might be affected by unwanted publicity' (Bartlett and Canvin, 2003:67).

Anonymity becomes a particular problem in the writing-up stage of qualitative research (Bartlett and Canvin, 2003) and protecting the identity of participants was far harder than I had envisaged. The media coverage led me to decide that the use of case studies to present the data was untenable. Some of the index offences of patients and prisoners and the specialised roles of staff made it impossible to provide much information without risking their anonymity. This demonstrates that in order to ensure confidentiality, researchers may have to remove far more than participant names (Bartlett and Canvin, 2003; Israel, 2004) and that 'the truth of research anonymity, in the context of qualitative research, is that it is not an all-or-none phenomenon; it is a matter of degree' (Bartlett and Canvin, 2003:65).

In order to ensure the confidentiality of participants, all data were anonymously coded as I went along. Unique numerical codes were allocated to patients and prisoners (e.g. 2035), PB members (e.g. PB1) and MHRT members (e.g. MHRT1). Before submission of my thesis I made sure to check with the DSPD Programme that they were happy with my anonymisation of the DSPD units, staff, patients and prisoners. They were.

It is important to acknowledge that my close proximity to the DSPD Programme and units is likely to have impacted on my approach to the study and interpretation of data. DSPD has been a controversial development, and one that continues to be closely watched by academics and practitioners from the UK and overseas. Since the early stages of my PhD I have worked closely with the DSPD Programme and been able to draw keys at each of the four high secure DSPD services for men. Although my PhD

was independently funded by the Economic and Social Research Council (ESRC), during the later stages of my PhD I was awarded extra funding from the DSPD Programme (through a sub-contract with Imperial College) to extend my research. I have also been required to regularly attend and present at the DSPD Research Forum (see DSPD Programme, 2008:22 for terms of reference), present to the DSPD Expert Advisory Group (EAG), discuss my findings with senior policy-makers from the Department of Health and the Ministry of Justice, and provide regular updates to the PB and the MHRT Service.

At the time of writing I have yet to submit my final report to the DSPD Programme, and as such the ending of my collaborative journey with government remains unknown. This is important because debate has already emerged between the DSPD Programme and external researchers about the publication of DSPD research (see Tyrer et al, 2009a, 2009b and Ramsay et al, 2009). In this sense the end of my methodological journey remains unknown. Delivering and disseminating the findings of my thesis and the larger study to the DSPD Programme, may present one of the biggest challenges yet.

## **Conclusions**

This chapter has explored some of the key features of my methodological journey. Based on my experience of conducting PhD research in high security settings, I have demonstrated that researchers may need to be flexible and opportunistic, in both their approach and method, if their research journey is to be successfully completed. This is a result of the inherently messy and unpredictable nature of qualitative research, and that:

[j]ust as the gardener needs to sow lots of seeds to be sure that some germinate and bear fruit, so much research has to take place as an act of faith.

We do not know what research will bear fruit ... there is still much about our ideas and knowledge that we do not understand, nor do we have any clue as to how to find out. What we do know is that knowledge is gained as much by undoing what we thought we knew as by accumulating new findings or facts. This unexpected result is a vital part of the research scenario ... research is full of surprises. Knowledge ends up being what it is, not just what we would like it to be (Brew, 2001:90).

It is for this reason that challenges along the research journey should be expected and regarded by the researcher as simply part of the business of conducting research in high security settings. Access to conduct research in high security institutions is challenging for good reason. In response to the challenges that arise, researchers must adopt a determined, proactive and resilient stance. While emotional responses should be cherished for their ability to motivate and develop insights, their impact on both the researcher and the research should be subject to reflection.

During the chapter I have also argued that data collection, analysis, and theoretical development cannot be conceived as separate stages, but must be developed simultaneously throughout the research journey. Having described the methodological journey of my study in this chapter, the chapter that follows outlines the theoretical framework that developed during the study and helped inform both my approach and analysis.

## 4. A theoretical framework of journeys, decision-making, and the unknowable

*The creating of any legal 'case' and its subsequent career are shaped by decisions made in a dynamic, unfolding process. Cases flow through the various handling systems employed in legal processes, their courses shifting or terminating at various salient decision points (Hawkins, 1983b:7).*

*Releasing a prisoner from high security into the community ... is not a good idea. Because, he just hasn't got any of the skills ... you can't just sort of open the door for him and push him out ... and expect him to behave normally. He's got to go through a journey (PB2, Independent member).*

### Introduction

Central to this thesis is the argument that prisoners and patients undergo a journey or career while in detention and along these journeys, many key decision-stages exist, including PB and MHRT reviews. At each of these decision-stages, participants are 'made up' (Hacking, 1986; McCallum, 2001) and 'made sense' of by report writers and decision-makers.

It is important to consider how patients and prisoners respond to admission to a DSPD unit, because it is a stage at which they are redefined as in need of specialist personality disorder treatment. Those with psychopathy can be presented as 'evil', 'beyond psychiatric help' (Mason et al, 2006:337) and as a 'species of humans suited to isolation' (Rhodes, 2002:458). This is significant because notions of evil can influence the planning of care (Mason et al, 2006; Mercer et al, 2000), while a

diagnosis of personality disorder can help reinforce and justify high security containment as a natural and right response (Rhodes, 2002:458). One problem that arises from this is that it becomes difficult for anyone to take responsibility for a prisoner's release to lower security (Rhodes, 2002). In this sense, personality disorder has the potential to be a 'disastrous label' and one almost guaranteed to extend the length of detention (George, 1998:106).

This demonstrates that 'language is significant in determining the individual's position and passageway through the mental health network' (Parker et al, 1995:72; see also Cohen and Taylor, 1972). Prisoner and patient characteristics, identities, and reactions to imprisonment can have important effects on future institutional careers (Cohen and Taylor, 1972; Ditchfield, 1990; Irwin, 1970), while the apparent effects of the prison experience and staff assessments of change, can, in turn, influence decisions made about transfer and release (Bottomley, 1973a; Crow, 2001; Irwin, 1970; Shalev, 2007).

With this in mind, the first half of the chapter explores how patients and prisoners may adapt and respond to secure institutions; observing that time, signals of progress, uncertainty and trust are important for patient and prisoner journeys. The chapter then considers some of the challenges that are raised by trying to know the unknowable in secure institutions. The second half of the chapter then turns to explore some of the key characteristics of decision-making, observing that decisions are structured by competing choices, objectives, and information. By focusing on the organisation of information, the processes by which participants are 'made up' (Hacking, 1986; McCallum, 2001) and 'made sense' of are explored. In this respect the chapter considers how patients and prisoners may respond to their detention, before turning to explore how the criminal justice and the mental health systems may characterise and respond to them. This is important because 'the study of particular problem populations

must account for the way in which categories of person are 'made up' and become known in order to be governed' (McCallum, 2001:36).

### **An interpretive approach to the study of journeys and decision-making**

In order to develop a better understanding of the institutional pathways of DSPD patients and prisoners, and how admission to a DSPD unit may impact on PB and MHRT decision-making, my organising theoretical framework derives primarily from Hawkins' (1983a, 1983b, 2002) work on decision-making<sup>41</sup>, although it is also informed by other interpretive and social constructionist approaches (Berger and Luckman, 1966; Best, 1989; Rein and Schön, 1994; Rose and Miller, 1992, 2008; Spector and Kitsuse, 1987; Stone, 2001). Hawkins (1983b, 2002) identifies the importance of an interpretive or naturalistic approach to the study of decision-making. This reminds us that:

[w]hat is understood as 'risky' or 'dangerous' about 'DSPD' *is as much* a product of historically, socially and politically contingent 'ways of seeing' as it is of 'objective', 'quantifiable' public health/psychiatric phenomena (Corbett and Westwood, 2005:122, italics in original).

Theoretically the thesis also draws from research that has employed the concept of a journey or career as a framework for making sense of the institutional pathways of patients and prisoners. Several researchers have used the concept of a 'career' to study offending and long-term imprisonment (Adler and Longhurst, 1994; Cohen and Taylor, 1972; Goffman, 1961; Irwin, 1970; Porporino and Motuik, 1995; Steadman and Cocozza, 1974; Toch, 1995; Toch and Adams, 1989, 2002). Its use dates back as far as Chicago School sociologists including Clifford Shaw (1930, 1931, 1938), and in

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<sup>41</sup> Hawkins (2002) acknowledges the influence of Peter K Manning (1992) in his work on decision-making. See also Manning (1986) and Manning and Hawkins (1990).

particular, Everett C Hughes (1937, 1958) and his students (see especially Becker, 1963 and Roth, 1963) who developed the concept of a 'career' as 'a lens for peering at larger social processes known as institutions' (Barley, 1989:49). Their work demonstrates that a focus on 'careers' offers a useful mechanism for linking individuals to institutions and for allowing us to move back and forwards between the self and society (Barley, 1989, Goffman, 1961).

Once individuals come to the attention of criminal justice/mental health services, they commence a journey through this system. 'Once created, an individual case in the legal system is typically moved from one decision-maker to another until it is resolved, discarded, or otherwise disposed of' (Hawkins, 2002:33). This demonstrates that following an offender's arrest, their journey through the criminal justice (and mental health) system may take on an 'obstacle-course nature' (Irwin, 1970):

The creating of any legal 'case' and its subsequent career are shaped by decisions made in a dynamic, unfolding process. Cases flow through the various handling systems employed in legal processes, their courses shifting or terminating at various salient decision points (Hawkins, 1983b:7).

Decision-making structures a number of interlinked stages of detection, detention, and later decisions about transfer or release (Bottomley, 1972, 1973a; Gottfredson and Gottfredson, 1988; Halleck, 1987; Hawkins, 1983b). This reminds us that decisions are the very 'business' of criminal justice and mental health systems (Hawkins 1983b) and 'critical to ... [their] ...efficient, effective and humane functioning' (Gottfredson and Gottfredson, 1988:2). 'Imprisonment is simply one stage of a journey' that offenders may have to make (Jewkes, 2007:xxiv), and decision-points should not be considered in isolation because:



to focus on a single decision point, or on a single type of decision, risks excluding the social context in which criminal justice decision-making takes place, the field in which the decision is set and viewed, as well as the interpretive and classificatory processes of individual decision-makers (Hawkins, 2003:187).

All decision-stages are crucial for the institutional pathways of offenders, but Maguire et al. (1984) argue that the decision to release is one of the most important uses of discretion in the criminal justice system. Traditional attention to decision-making at the time of sentencing helps conceal the fact that, while the length of a sentence may be indicated by a Court, in practice, its nature and duration are often determined by a number of other decision-makers including the PB (Bottomley, 1973b; Creighton, 2007; Maguire et al, 1984; Padfield, 2007) and the MHRT. PB and MHRT decisions have particular symbolic significance because they are:

formally organised as the occasion for further legal categorisation of the deviant. It is the point at which a prisoner ... may have his identity transformed. Having been the incarcerated deviant ... he now has the opportunity to have the label of deviance lifted ... and to be re-designated as having paid the price (Hawkins, 1983a:104).

### **Secure institutions and patient and prisoner responses to detention**

A number of researchers have considered how individuals may adapt and respond to detention in a secure institution (see Clemmer, 1940; Cohen and Taylor, 1972; Flanagan, 1995; Goffman, 1961; Irwin, 1970; King and Elliott, 1977; Mathiesen, 1965; Pope, 1979; Sapsford, 1983; Sykes, 1958; Toch and Adams, 2002; Zamble and Poroporo, 1988). Many 'pains of imprisonment' have been identified by this literature, including loneliness, loss of key relationships with family, friends and communities, the

loss of goods and services, absence of sexual relationships, deprivation of autonomy, and fears about personal security (Sykes, 1958, see also Flannagan, 1980).

Goffman (1961) argues that patients in hospital tend to adapt rather than resist, and suggests four strategies of adaptation: *situational withdrawal*; *intransigence*; *colonization*; and *conversion*. These strategies indicate that patients seek to manage better the tensions between their inside and outside worlds, and that as residents within a total institution they operate in accordance to a 'calculus of risk'; that is, they learn to work out what behaviour they can get away with and the cost of non-compliance. Goffman also observes that patients rarely adopt one strategy, but instead:

take the tack of what some of them call 'playing it cool'. This involves a somewhat opportunistic combination of secondary adjustments, conversion, colonization and loyalty to the inmate group, so that the inmate will have maximum chance, in the particular circumstances, of eventually getting out physically and psychologically undamaged (Goffman, 1961:64).

Irwin (1970) distinguishes between three adaptive strategies in prison: those who are *doing time* and continue to have a commitment to life outside; those who are *jailing*, largely cut-off from their outside worlds, and often lack links to the outside because of their institutionalisation; and those who are *gleaning*, in that they are trying to effect change in their lives during their imprisonment. While some research has found that prisoners tend to follow a path of least resistance, because it is 'easier to serve time, as they were sentenced to do, by passing through it, rather than using it' (Zamble and Porporino, 1988:150), other research has identified that trying to make use of their time is important for long term prisoners (Irwin, 1970; Toch, 1995).

Rather than adapt, others have considered how prisoners may resist. Cohen and Taylor (1972:154-172) suggest five typologies of resistance, based on 'the nature of their relationship with authority': those who engaged in direct *confrontation* with the institution and actively resisted adjustment; those who had more *symbiotic* criminal careers; those whose relationships with authority were characterised by *trumping and outflanking* authority; those termed *private sinners*, most often sexual deviants, who avoided confrontation, and tended to live their lives 'within their own heads'; and finally, drawing on the work of Maurice Farber, those they describe as *situational criminals*, whose institutional careers did not fit into any clear strategy.

Toch and Adams (2002:75) found that inmate attributes led them to be able to distinguish between three main career types: *non-disruptive*, *early starter*, and *chronic*; concluding that non-disruptive and chronic careers involve very different prisoners. Offenders with chronic careers were more likely to be younger, newcomers to crime, have a history of violence, and a record of admission to psychiatric hospitals. Similarly to Cohen and Taylor (1972) they found that an index offence was often revealing in terms of a prisoner's institutional career, with those convicted of murder or rape more likely to be non-disruptive, and those convicted of assault or burglary more likely to adopt a chronic career. This reminds us that pre-institutional behaviour is an important factor in understanding behaviour in prison (Cohen and Taylor, 1972; Ditchfield, 1990; Irwin, 1970).

While considerable variation in modes of adaptation to secure institutions have been observed, Mathews (1999:55) argues that sociologists have essentially identified three types: *co-operation or colonization*, where prisoners 'aim to keep out of trouble and do their time with the minimum degree of conflict and stress'; *withdrawal*, which can take a number of forms ranging from 'physical separation from other inmates, engaging in minimum degrees of communication, depression, or self-mutilation and suicide'; and

finally, *rebellion and resistance*, which may involve 'engaging in riots or disturbances at one extreme, and forms of non-co-operation at the other'.

All of these strategies of adaptation are evident in the reports of DSPD patients and prisoners, especially prior to their admission to DSPD services. Prior to admission, very few patients and prisoners are described as co-operative. Most are presented as rebellious and resistant, although many of these are also presented as vulnerable and withdrawn. Following DSPD admission, the majority of prisoners, in contrast to their previous reactions to imprisonment, are depicted as largely co-operative, rather than disruptive. In contrast, many DSPD patients, particularly those transferred to a hospital DSPD unit towards the end of their prison sentence, continue to be recorded as disruptive. This demonstrates that co-operation is dependent on perceptions of fairness and legitimate treatment (Liebling, 2007; Sparks et al 1996) and patients and prisoners may adopt a range of modes of adaptation during their time in institutional settings.

Sapsford (1983) argues that reactions to imprisonment are structured by a prisoner's expectations. Indeterminacy can lead to a strong source of anxiety and feelings of powerlessness amongst life sentence prisoners because everything a prisoner does is open to inspection and interpretation. As a result, 'most lifers go through a phase of anxiety, depression, withdrawal and/or belligerence as they try to come to terms with their new situation' (Sapsford, 1983:82). In response to the depression of self image, Sapsford suggests that lifers may adopt and construct alternative identities to manage their time inside, and as they settle into their sentence may move from an anxious position to one that is marked more by passivity, apathy and dependence.

This indicates that prisoners who are confrontational often come to realise that it is not a strategy that enjoys any long-term success (Cohen and Taylor, 1972:174). Towards the later stages of a sentence, as prisoners begin to anticipate release, they may

become more anxious (Toch and Adams, 2002:91). Some prisoners may choose to opt out of parole because of low expectations and a poor tolerance of uncertainty (Nuttall, 1977). This highlights that patients and prisoners may adopt a number of different roles during their detention (Sykes, 1958) and that the length and stage of a sentence may have a significant impact on styles of adaptation.

This draws attention to the significance of time (Cohen and Taylor, 1972; Sparks et al, 1996; Wahidin and Powell, 2001) and the importance of signals of progress (Roth, 1963, Sapsford, 1983) within institutional settings. Drawing from Roth's (1963) research concerning the significance of benchmarks and timetables for patients with tuberculosis in managing their hospital careers, Sapsford (1983) identifies that prisoners 'break-up' their sentence based on their awareness of a hierarchy of progress before release. Transfers between prisons, job allocations, and changes to security classification are all visible forms of progression, and because prisoners do not know when they will be released, these events act as signals of progress (Sapsford, 1983) and "'messages" about their chances' (Maguire et al, 1984:253).

This reminds us that in the total institution, questions of release are built into the rewards system (Goffman, 1961:53) and used as an incentive and a mechanism for maintaining institutional discipline (Appleton and Grover, 2007; Barnard, 1976; Hawkins, 1973; Maguire et al, 1984; Proctor and Pease, 2000). Toch (1995:248) argues that long term prison careers should involve planning to enable 'progression from higher- to lower- security settings, with increments of freedom and amenities' (Toch, 1995:248). As a result, privileges and decreases in supervision are:

desired not only in themselves, but for their symbolic value. They are signs that the treatment is progressing ... [and] ... that the patient is getting closer to discharge (Roth, 1963:4).

Signals of progress are worked out tacitly between the prisoner and the institution to provide 'at least some semblance of landmarks' (Sapsford, 1983:79). Importantly, while Cohen and Taylor (1972:94), found that parole was symbolic as a reward for progress, many prisoners saw their chances of parole as nil, and therefore not a progressive stage. Similarly, Peay (1989:43) observed that patients were aware that MHRTs do not 'readily make discharge decisions'. Despite this lack of knowledge about when they may be released, patients and prisoners may be 'continually stimulated to hope for release by review procedures' (Sapsford, 1983:22).

Long-term patients and prisoners tend to measure and interpret their progression by comparing their careers with others (Roth, 1963; Sapsford, 1983, see also Barley, 1989). As a result of conversations amongst patients, progress clues become a group product and the patient 'never stops watching for clues that may help him guess what stage of the treatment process he has reached' (Roth, 1963:xvi). Progress clues are used by both patients and staff to develop a set of norms to anticipate the future and 'help them make "reasonable" decisions in a highly uncertain situation' (Roth, 1963:xvii). Staff and patient ideas of what constitutes progress may differ (Roth, 1963; see also Duggan, 2007), with the:

official image of the felon, the explanation of his acts, the definition of the programs ... quite different than the felon's view of these same things (Irwin, 1970:3)

Drawing from Adams' (1995) concept of a 'risk thermostat' that requires the balancing of the likelihood of reward with the likelihood of accidents, Duggan (2007:118-119) reminds us that staff and patients in the DSPD services will approach the balance of rewards and accidents very differently. For the patient, a transfer to lower security is viewed as a 'reward'. The consequences of an accident are 'almost inconsequential',

because if they are to fail, the worst that will happen is that they are returned to high security (Duggan, 2007). In contrast, the rewards and potential for accidents are viewed very differently by the staff. The reward comes from doing one's job and being able to move an individual through the system but this must be balanced with the likelihood of reoffending, for which the staff will be required to take much of the blame (Duggan, 2007). 'From the patient's perspective, therefore, all of the advantages lie in making the transition whereas, from the professionals' perspective, it is the direct opposite' (Duggan, 2007:119).

Conceptions may also differ amongst staff because they 'do not always see the same problem as the treatment responsibility transfers from one staff member to the next' (Toch and Adams, 2002:87). This is important because, 'progress' does not necessarily imply an increasing knowledge and understanding, but can instead refer to the number of completed treatment courses (Roth, 1963). This is important in the context of PB and MHRT decision-making, because it may be that the number of accredited offending behaviour courses completed is more significant than the actual progress made. These observations indicate that conceptions of progress, and assessments of risk, in DSPD services are likely to be constructed differently by patients and prisoners, prison and hospital staff, and external decision-makers like the PB and MHRT.

As a result, patients may come to define their experience in accordance with professional understanding and definition of illness (Barrett, 1988 in Parker et al, 1995; Crewes, 2006). Programmes enable prisoners to adopt a 'vocabulary of adjustment' in order to convince unit staff, the PB and other external agencies that they have made the necessary improvements while in prison (O'Leary and Glaser, 1972:163). This may be motivated by a patient's or prisoner's desire to manipulate his own destiny (Irwin, 1970), but also highlights that if a patient or prisoner goes against this formal vocabulary they may be at risk of being discredited.

In the case of life sentence prisoners, Sapsford (1983) argues that staff face a similar situation to the prisoner, in that they are powerless to influence the date of release, and must also guess when this may be. Although Roth (1963) found that staff do not like being pinned down to give precise estimates of how long treatment will take, staff have the capacity to project patient careers (Richman, 1998), and those who control the careers of others must decide about appropriate times for making changes (Roth, 1963). Despite uncertainty, staff must decide on an appropriate timetable for the patient, and a clinician must 'defend his decisions against pressures to change them. He must seem more certain than he really is' (Roth, 1963:111).

The uncertainty that surrounds the DSPD programme may be significant for the construction and management of patient and prisoner journeys, because ambiguity amongst staff can be used by the patient group to help absolve responsibility (Richman, 1998:151). DSPD participants need, where possible, to know how long they will be expected to engage with DSPD therapy and what their future journeys through the criminal justice and mental health system may look like. 'Once there are delays in progress, patients become more difficult to motivate and manage' (de Boer et al, 2008:160). Patients who are difficult to motivate and manage are likely to impact on the motivation of other patients, and the staff group. The difficulty with this is that there is still much we do not know about DSPD, and a:

delicate balance exists between offering realistic hope for the future without imparting false hope, especially as DSPD services are managing incredibly difficult clients within an underdeveloped evidence base (Maltman et al, 2008:14).

Because of the uncertainty that surrounds DSPD as a concept and as a treatment programme it is essential that DSPD patients and prisoners are able to conceive their



futures. If they consider their futures to be unknowable it is understandable that they may struggle to invest in the treatment programme. It is important to remember that visible benchmarks are also important for external decision-makers like the PB and MHRT, and are likely to be important for staff in DSPD and other forensic services, because:

[w]hen treatment methods undergo a sudden shift, not only do the patients have greater difficulty anticipating their future careers, but the ... [staff] ... also become more doubtful about when patients should be given privileges or discharged – until a new set of norms to accompany the new treatment has been worked out (Roth, 1963:100).

These observations highlight some of the potential challenges for decision-making about DSPD. DSPD has emerged in an uncertain context and been subject to some considerable debate. How DSPD staff, prisoners, patients, PB and MHRT members manage, and make decisions about the unknown and unknowable uncertainties that surround DSPD, are important to explore. The chapter now explores the importance of knowledge in secure institutions before turning to consider the key features of decision-making.

### **Knowing the unknowable**

The DSPD units have been described as reminiscent of Goffman's 'total institutions' and Bentham's 'Panopticon', in which, 'the feeling of being constantly watched leads one to a kind of self regulation' (Freestone, 2005:456). The four high security units are some of the most expensive and secure units in England. Often described as prisons within prisons, three of the units have been newly built and are situated within additional security fences. Surveillance is a constant feature, with physical, procedural and relational security all high on the agenda. For those detained within the units, the

daily routine is often highly structured, and where possible, the activities of those on the DSPD unit are separated from activities of other patients or prisoners in the host institution. This highlights that in total institutions discipline is partly accomplished by reordering time and space (Turell, 1990), and that routines are important for the 'continual reproduction of order and the psychic securing of individuals' (Bottoms, 1991:13).

The thesis argues that DSPD represents an attempt to generate certainty by trying to know the unknowable. We have become increasingly interested in knowing the offender not just for reasons of security, but also for treatment (Foucault, 1978). Today, more is expected from the patient or prisoner, and mechanisms of control in the criminal justice system are both physical and psychological (Cullen and Newell, 1999). Now, it is 'necessary as a precondition for effecting treatment, first to *know* the criminal' (Parker et al, 1995:76) and to ask the criminal 'who are you?' (Foucault, 1978).

Control in risk society is not simply about containing those who are regarded as risky; it is also about the generation of knowledge (Ericson and Haggerty, 1997; Rose, 1998). Those categorised as DSPD must 'become known in order to be governed' (McCallum, 2001:36; see also Greig, 2002; O'Malley, 2001). In order to govern a population we require 'intellectual technology' (Rose, 1999b) that can 'identify certain characteristics and processes proper to it, to make its features notable, speakable, writable, to account for them according to certain explanatory themes' (Rose, 1999a:6). Risk thinking, like that which structures DSPD, attempts to 'discipline uncertainty' by making it the focus of 'learning and instruction' thereby making it 'orderly and docile' (Rose, 1998:180).

Rehabilitation has become a 'form of moral regulation – an exercise in governance that specifically tries to change the relationship that the individual has with himself and

others' (Lacombe, 2007:18). The closed world of the security unit, akin to a 'submarine' (Cohen and Taylor, 1972) or a 'goldfish bowl' (in the words of some of the DSPD population) may lead to a struggle on behalf of the prisoners to hide themselves (Cohen and Taylor, 1972). Following admission to a secure institution 'there must be confession, self-examination, explanation of oneself, revelation of what one is' (Foucault, 1978:2). Individuals must confess and 'expose acts and feelings about self to new kinds of audience' (Goffman, 1961:32), for:

therapy is not something which is 'done' to a person or 'happens' to them; it is an experience which involves the individual in systematic reflection about the course of her or his life development (Giddens, 1991:71).

Participant engagement in DSPD treatment is dependent upon trust, and the decision to engage, like any decision, involves a degree of risk. Trust is important because it 'entails a commitment that is a "leap into the unknown", a hostage to fortune which implies preparedness to embrace novel experiences' (Giddens, 1991: 41). Lacombe (2007:18) argues that a:

treated sex offender is 'made up' (Hacking, 1986) into what could be called a 'confessional machine' – someone expected all his life to narrate his darkest fantasies to criminal justice officers and significant others who are enlisted to help him control his risk.

This may be problematic because 'dialogue can promise freedom, but at some time provide a rationale for continued detention' (Mercer, 1998b:124). Research has shown that prisoners are aware that their honesty may lead to negative consequences (Attrill and Liell, 2007), and that often 'it was the men's own confessions that led the consultants to feel serious concern about future dangerousness' (Dell and Robertson,

1988:65). The cultures of prison and hospital mean that patients and prisoners have much to gain from the concealment of their behaviour (Mercer, 1998b) because:

the therapeutic process of exploration and expansion brings out a truth that may not be in the patient's interests. An honest truth emerges about an individual that casts them in a much worse light than had been anticipated. As a result of the therapeutic exploration, the individual is materially worse off after treatment than they were before (Morris, 2004c:22).

This highlights an important double-bind that may be faced by DSPD patients and prisoners, which is extenuated because their futures are largely unknown. This may lead engagement with DSPD treatment to become a game of truth, where knowledge is restricted and controlled at many points. The participant may decide not to fully disclose, a selective picture of the participant can be presented by unit staff, and the PB and MHRT can choose what information they give significance to. This demonstrates that there are many decisions involved with the detention of DSPD patients and prisoners, and that uncertainty has the capacity to disrupt them. Having outlined the importance of participant journeys and knowledge for secure institutions the second half of the chapter explores some of the key characteristics of decision-making that may impact on these institutional journeys.

### **An interpretive approach to decision-making**

Hawkins' earlier work alerts us to the importance of being sensitive to the structure, substance and process of decision-making (1983b), while his later work reminds us that it is important to locate decision-making within its *surround*, the broad setting and wider context in which decision-making takes place, its *field*, the defined setting in which decisions are made, and to take account of *decision-frames*, that is, the

'structure of knowledge, experience, values, and meanings that decision-makers employ in deciding' (Hawkins, 2002:52; see also Goffman, 1961, 1974; Manning, 1992; Manning and Hawkins, 1990; Rein and Schon, 1994). This is because:

changing elements in the surround, such as the dominance of 'populist punitiveness' or media campaigns, can have a significant impact on the decision-makers' field, in the form of changes in law or policy. These latter changes can in turn affect decision-making in actual cases (Hawkins, 2003:201).

In order to understand PB and MHRT decision-making, we need to look beyond the formal legal structures that form the basis for the penal process, and consider the ideological, symbolic, socio-political, economic, organisational and moral constraints within which decision-makers work (Bottomley, 1973a; Hawkins, 1983b). This a consequence of PB and MHRT decisions about release operating within a 'formal system (rules, regulations, statutes, norms) and an informal system (attitudes of parole board members, public sentiment, custom and values)' (Thomas, 1963:173).

At all stages of the criminal justice/mental health system a number of decision-makers have a variety of objectives, choices, discretion, and sources of information, that may affect their decisions about how to handle a case. Before a decision can be made, decision-makers must assess what the decision is about, why it is important, and what the possible outcomes may be. This demonstrates that decision-making is not a simple event, but rather, a process that takes place over a course of time (Bartlett and Sandland, 2007; Hawkins, 2003; Padfield and Liebling, 2000a; Peay, 1989).

Many individuals are involved with the process and decision point of a PB or MHRT review, including PB and MHRT members, report writers in the DSPD units, the

patients and prisoners, the MoJ, and gatekeepers from lower security services. Hawkins (1983b) reminds us that criminal justice decisions are rarely taken by individuals alone, and instead usually rely on information flows between different decision-makers. Here, many different types of interaction can be observed, ranging from interactions between cases, the environments within which case outcomes are decided, and between decision-makers, information suppliers and decision-subjects (Hawkins, 1983b).

It is important to consider how knowledge transfers between different decision-actors, their role in the characterisation of DSPD patients and prisoners, and how this may impact on the conduct and outcome of PB and MHRT reviews. At the stage of a PB/MHRT review the identity of DSPD participants may or may not be reconstructed as a result of a number of decisions, by the patients and prisoners themselves (e.g. shall I engage?), the units (e.g. what information shall I include in this report?), to the PB/MHRT (e.g. what is the important information in this report, and should this person be released?).

Many theories of decision-making assume a rational choice model in which the decision-maker seeks to maximise the outcomes by choosing the most beneficial course of action. However, decision-making 'is not simply a set of rational calculations about the cost and consequences of violators or violations, but rather the social construction of action' (Thomas, 1986:1290). Although many decisions are presented as rational:

the perfectly rational decision-maker is to politics what the saint is to religion – an ideal everyone publicly espouses, most people would not want to live by, and precious few attain (Stone, 2001:233).

Although Gottfredson and Gottfredson (1988:vi) observe that decisions can rarely be said to be rational, they identify three fundamental characteristics of decisions: first, that the presence of a decision implies a choice amongst alternative courses of action; second, that decisions involve a particular 'set of goals, purposes, or objectives to be achieved'; and finally, that decision-makers require information to make a decision. While decision-making is elusive and difficult to capture, this chapter now turns to consider each of these characteristics in more detail.

### ***Choices amongst alternative courses of action***

PB and MHRT decision-makers must search, evaluate, and choose between a number of alternatives courses of action. Without a choice, there would be no decision to make. While choices may feel restrained, they exist at every stage of the criminal justice system, and can be affected by a number of factors other than the law (Bottomley, 1973a) including:

a practitioner's experience and case-load, the resources available, the objectives being pursued by any one practitioner, the climate of opinion, and/or an individual's ability to tolerate risk and uncertainty (Peay, 2005:55).

Choices are affected by resources, and 'a critical process in social control decision-making is how to *allocate resources* among the particular cases that make up a larger whole' (Emerson, 1983:439). Consequently, classifications of people are often a 'by-product of resource allocation' (Toch and Adams, 2002:22) and the journeys of mentally disordered offenders can depend more on their postcode than their needs (Chiswick, 1996 in McCann, 1998). This is evident by the availability of DSPD services in lower security being determined by NHS and NOMS catchment areas.

Choices are permitted by discretion, and vary according to the different types and locations of legal authority to make decisions (Hawkins, 1983b). Some decision-makers are privileged with a high degree of discretion (for example, Judges in the Crown Court) and different decisions will themselves allow for varying degrees of discretion (there is less discretion, for example, with life sentence prisoners and patients detained under mental health legislation and subject to a restriction order).

The presence of different choices reminds us of the importance of decision-outcomes. Hawkins (1983b) distinguishes between binary and graded decision-outcomes. One of the ways that legal decision-making is simplified and made workable is to consider things in terms of opposing alternatives (Hawkins, 1983b). 'This binary logic is particularly evident in the way in which the law provides answers to problems: that is, the way in which it produces decisions' (Hawkins, 1983b:12). Binary decision outcomes can be problematic when forced to interact with medical decision-making that often looks at phenomena in terms of degrees, reminding us that clinical and legal definitions of a problem do not sit well together (Scully, 1990).

Sometimes, of course, decision-makers may decide to do nothing. This has led Hawkins (1983b) and Peay (2005:54) to observe the phenomenon of 'decision avoidance' whereby decision-makers prefer to defer decisions to others. Deferred decisions are often used as a bargaining ploy (Hawkins, 1983b) and can clearly be observed in the context of PB and MHRT decision-making as the panels may suggest that transfer or release should take place but not until certain criteria are met. Here Hawkins (1983b:12) questions whether these are 'decisions to release or decisions to deny'.



### ***Competing aims and objectives***

People often do not know what they are weighing up when they make a decision, and the goals of making a decision are not always clear (Hawkins, 1983b; Gottfredson and Gottfredson, 1988). In practice, this means, 'it is commonplace for many of our decisions to be based on fear, uncertainty and occasionally, frank ignorance' (Peay, 2005:41).

While the goals of decision-making may not always be clear, decisions are nevertheless made on the basis of a number of objectives. At each stage of the criminal justice system 'decision-makers are confronted with the usual, sometimes conflicting, demands of the criminal justice system for punishment, societal protection and rehabilitation' (Gottfredson and Gottfredson, 1988:7). Decisions also involve assessments of responsibility and guilt (Mercer, 1998a). Moreover:

[i]n making judgments about release or restraint, a Parole Board is engaged in the appearance of condoning or condemning criminal behaviour; it is making statements about good and evil, desert and punishment, to the prisoner, the institution, and the wider community. The parole decision, in short, is symbolically significant (Hawkins (1983a:102).

The construction of offenders is also dependent on the passage of time; it is only once prisoners have served enough time in prison and reached a moral threshold, that the participant's identity can be cast aside to enable a new one to be generated (Hawkins, 1972, 1983a, 1983b; Irwin, 1970; Maguire et al, 1984, see also Dell and Robertson, 1988 and Peay, 1989). This suggests that the decision by a PB or MHRT to release (or not), is tied up with a number of other judgments, and is not just used to permit 'safe' offenders back to the community but also to help assist in the management of penal institutions (Hawkins, 1972 in 1983b). It is for this reason that PB decisions can have

‘profound implications for management and morale of the prison community’ (Hawkins, 1973:9)<sup>42</sup>.

### ***Processing information and knowledge***

Decision-makers rely on information and knowledge to impose order and bring control to a characteristically uncertain and potentially disordered world (Hawkins, 1983a). The concept of DSPD and the likelihood of treatment success are largely unknown; yet PB and MHRT members must still make decisions and offer justifications for them. In order to make sense of the data available to them, Hawkins (1983b) suggests that decision-makers draw on a number of overlapping techniques including simplification, presumption, characterisation, and patterning. Other theorists draw our attention to equally important and often overlapping concepts of problem definition (Rochefort and Cobb, 1994), typification (Best, 1989), classification, and prediction (Gottfredson and Gottfredson, 1988). The use of these techniques varies according to what the decision is, who is responsible for making it, and where in the criminal justice/mental health system the decision is being made. While these techniques are not mutually exclusive, for ease of discussion, the chapter now explores the four mechanisms for organising knowledge suggested by Hawkins (1983b).

*Simplification* is involved with most decision-making tasks and highlights the need for ‘economy in the use of data’ (Hawkins, 1983b:15) and the necessity of avoiding ‘analysis paralysis’ (Stone, 2001:233). ‘Actors cannot handle the infinite variability of the real world without simplifying it’ (Manning, 2000:627). It would be impossible for a decision-maker to know everything about a case, nor desirable. This reminds us that PB and MHRT decision-makers ‘use cues to make decisions based on limited information’ (Huebner and Bynum, 2006:980) and that information like that generated

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<sup>42</sup> This is an important point and one that is explored further in the wider study and report to the DSPD Programme.

in the DSPD units 'must be made intelligible to non-specialists who have the authority to decide' (Reiss, 1989:396).

As a result, data are often summarised and broken down into categories. Within a report, index offence and treatment history become significant categories of information for decision-makers. Similarly, complex behaviours and symptoms are categorised and simplified by the use of diagnostic classifications. This means that the reports and case records given to external decision-makers like the PB and MHRT represent 'the archaeology of and sedimentation of many decisions' (Manning, 1986:1297) and an 'extremely complex interpretive history of the offender's prison career' (Thomas, 1986:1288):

One of its purposes is to show the ways in which the patient is 'sick' and the reasons why it was right to commit him and is right currently to keep him committed; and this is done by extracting from his whole life course a list of those incidents that have or might have had 'symptomatic significance' (Goffman, 1961:144).

Through the process of simplification different significance is attached to data (Hawkins, 1983b), together with 'explicit and implicit evaluations that assign a particular meaning to a case' (Thomas, 1986:1274). Decisions about what to include in a report may be as significant as subsequent decisions made by PB and MHRT members about what information to give weight to. Patients and prisoners 'must bargain for the suspension of the criminal sanction not only with the Parole Board, but also with those supplying it with information' (Hawkins, 1983a:104). This reminds us that information suppliers are also decision-makers, and the choice of words, evidence and opinions that are found within the reports submitted to the PB and MHRT, can be highly significant:

[I]nformation suppliers are important actors because they are at the heart of those decision-making processes that frame in certain facts potentially bearing on the composition of a case to be decided about, or frame out those other materials deemed irrelevant or otherwise unnecessary (Hawkins, 2003:192).

The second technique of organising knowledge suggested by Hawkins (1983b) is *presumption*. Through previous interaction, decision-makers make presumptions about whether the accounts of others are (in)accurate or (un)reliable. Certain information in a report, may lead the decision-maker to believe that its very presence must mean something (Hawkins, 1983a). Often the *source* rather than the *substance* of data will be considered more important (Hawkins, 1983b). Peay (1989), for example, has identified that the Responsible Medical Officer's (RMOs) opinion, is a privileged source of information, from which the MHRT rarely deviate. Others have found that the experience, reputation, and language used by RMOs and Independent Psychiatrists (IPs) is related to the significance attached to their evidence (Holloway and Grounds, 2003).

These observations remind us of the importance of expertise for decision-making. Expertise is important for decision-making because it can 'confer particular credibility upon the decision outcome' by making it seem rational (Hawkins, 2003:203), and decision-makers may be prepared to 'defer' to other professionals 'on the basis of what [is] perceived to be privileged knowledge' (Peay, 2005:53):

A decision whether to parole a prisoner seems qualitatively better and fairer if the process allows knowledgeable people to speak to his or her character than if it does not, regardless of the outcome of the decision (Stone, 2001:234).

The difficulty in the context of DSPD is that experts are divided about the treatability of individuals with severe personality disorder, and the futures of the concept, programme and participants remain unknown. The development of DSPD services in both the Prison Service and the mental health system is likely to have added to this uncertainty. As a new treatment programme, PB and MHRT decision-makers must make sense of a range of expertise provided by multi-disciplinary experts, from both inside and outside of the DSPD units. External experts, like those who submit independent reports to PB and MHRT reviews are often employed by the patient and/or his legal representative, and consequently have different aims for which they seek to use their expertise. This has led to some considerable debate, particularly in the mental health system, about the legitimacy of expertise, with some DSPD clinicians describing external experts as ‘rent-a-experts’ who are entering into discussions about issues that they do not know<sup>43</sup>.

While expertise surrounding DSPD is in the process of becoming known, external decision-makers like the PB and MHRT must nevertheless make judgments now about a highly uncertain future. To achieve this, they must make assumptions about the credibility and plausibility of different expert accounts. In a court of law, just as in a PB or MHRT, it is the plausibility of different accounts that matters rather than the ‘truth’ of them; this means that DSPD unit staff and independent experts must make their accounts persuasive. In practice this may be difficult because different discourses, experiences and sources of information, are not equally compelling or acceptable (Rein and Schön, 1994).

*Characterisation*, the third technique for organising knowledge suggested by Hawkins (1983b), is a process by which individuals are given attributes that help decision-makers make sense of them. A focus on the way people and problems are defined

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<sup>43</sup> The views of DSPD staff are considered in the wider study and report to the DSPD Programme.

helps demonstrate that language, classification tools, and risk assessments not only describe a 'truth', but also produce them (Hawkins, 1983b). This reminds us that classification is both a technique of knowledge and power (Turkel, 1990). This is important because 'official definitions of offenders and patient status describe the responses of agencies as well as the behaviour of the persons responded to by the agencies' (Toch and Adams, 1989:24) and reflect the 'core concerns of a particular social system' (Adler and Longhurst, 1994:82).

Although once a radical idea, it is now generally accepted that definitions of madness change according to time and context (Parker et al, 1995), and that the status and characteristics assigned to individuals are liable to change (Glaser and Strauss, 1971). There is always 'a clause, whether hidden or openly acknowledged, whereby a man may be dispossessed or may dispossess himself of the status' (Straus, 1970 quoted in Glaser and Straus, 1971:3). Writing over twenty years ago, Stanley Cohen (1985:194-5) observes:

All that has changed over the last century is the basis of the binary classification. It used to be 'moral character'; sometimes it was 'treatability' or 'security risk', now it tends to be 'dangerousness'.

The way behaviour is characterised can lead to the accounts of prisoners being treated with scepticism, with even seemingly good behaviour redefined as manipulative (Hawkins, 1983b:16). Prisoners who are open about their crimes may be perceived by some decision-makers as open and remorseful, but as callous and manipulative by others (Hawkins, 1983b). Characterisations can also lead to a 'master-slave mentality' where, for example, if a prisoner chooses to stay in his cell and not make friends he may be defined as 'withdrawn', while others who choose to associate with the wrong groups will be defined as 'subversive' (Sapsford, 1983). This highlights that DSPD

patients and prisoners may face a double-bind about whether to present as knowable or unknowable. By offering themselves up to become knowable, they may generate the very anxieties about their risk that they wish to avoid. Yet, if they present as unknowable and as wishing to remain hidden, they will continue to be considered a high risk. This double-bind is extenuated when one remembers that their futures (in terms of treatment success and progression) at this stage are largely unknowable.

The histories of DSPD patients and prisoners reveal that those labelled as having a high PCL-R score have often been classified as 'unsuitable' for particular offender behaviour treatment programmes and institutions. This demonstrates that 'membership of a category often presupposes a particular outcome' (Hawkins, 2003:198, see also McCleary, 1978:105) and is significant because previous classifications can affect a prisoner's chance of parole (Shalev, 2007). As a result, patients and prisoners must remain sensitive to their behaviour and its interpretation at all times, because:

language is a means by which characterisations developed by other criminal justice officials can subtly permeate a prisoner's records and deliberately or unwittingly influence subsequent decision-making (Hawkins, 1983b:17).

*Patterning*, the final technique of organising knowledge suggested by Hawkins (1983b), is used to organise information and derive a meaning that helps position a particular response as appropriate. Through the process of decision-making, deviant biographies and careers are created and an offender's criminal career or institutional behaviour can take on meaning in itself (Hawkins, 1983b:17). One example of this is the creation of a 'criminal career', where 'meaning is derived ... from the distribution of deviance over time, and the juxtaposition of one kind of deviant act with another' (Hawkins, 1983b:18). Meaning can also be derived from admission to a particular type of

institution (Goffman, 1961; Hawkins, 2003; Padfield, 2002; Rhodes, 2004; Shalev, 2007). Indeed:

the interpretive scheme of the total institution automatically begins to operate as soon as the inmate enters, the staff having the notion that entrance is *prima facie* evidence that one must be the kind of person the institution was set up to handle (Goffman, 1961:81).

This highlights that ‘an institution which is known to hold a particular type of prisoner or patient sets up expectations in decision-makers about the types of person and problem they are likely to encounter’ (Hawkins, 2003:193). Similarly, security classification (Padfield, 2002; Price, 2007; Shalev, 2007), labels of personality disorder (George, 1998; Rhodes, 2002) and dangerousness (Blackburn, 1996; Chin, 1998; Maguire et al, 1984) can have a significant impact on decision-making about release:

Any indication of dangerousness, past or present, seemed to have an effect on the length of time served by a lifer and upon his chances of release at any one hearing (Maguire et al, 1984:262).

This indicates that certain characteristics may predetermine the institutional journeys that patients and prisoners experience. This may generate difficulties for the patients and prisoners trying to evidence change, and patients and prisoners may again find themselves in a double-bind because of their inability to change their previous characterisations. Because the ‘typing decision occurs at the very beginning of the parole experience, outcomes are largely predetermined, with no allowance for retyping’ (McCleary, 1978:105). How they are defined at one point of their institutional career can have a significant impact on how they are made sense of by external decision-makers like the PB and MHRT. Indeed:



[o]nce prisoners are classified to a certain security category, their institutional placement, provisions, entitlement to 'privileges', access to programmes and entire experience of the prison system are predetermined to a very large extent (Shalev, 2007:107, see also Price, 2000).

These observations demonstrate that prisoners carry a 'residue of prior handling decisions which are selectively treated as highly relevant' by PB (Hawkins, 1983b:17) and MHRT decision-makers. This exposes the connections between different parts of the criminal justice and mental health systems and demonstrates that decisions taken at one stage, will be affected by past decisions, and will influence decisions taken in the future (Bottomley, 1972; Emerson, 1983; Gottfredson and Gottfredson, 1987; Hawkins, 1983b; Padfield, 2007; Peay, 2005, 2007; Shapland, 1983). It is for this reason that it is important to explore what impact placement in a DSPD unit may have on the subsequent decision-making of external decision-makers like the PB and MHRT.

## **Conclusions**

Drawing from the theoretical framework outlined above, the four data chapters that follow explore how DSPD patients and prisoners and their journeys have been presented by report writers to the PB and MHRT, and what sense PB and MHRT decision-makers have made of DSPD patients and prisoners and their responses to detention. Given that the development of DSPD services can be situated within a context of uncertainty and debate, it is important to consider how DSPD may impact on PB and MHRT decision-making. Decisions made about dangerous offenders are particularly risky, because the 'wrong' decision can have significant implications, either because someone who still poses a risk is released and goes on to seriously offend, or someone who would not have gone on to reoffend is kept in detention. This highlights a long standing struggle with the problem of false positives and negatives.

Chapter five considers how participants and their institutional careers prior to DSPD admission are presented to PB and MHRT decision-makers. The chapter pays particular attention to the background of DSPD patients and prisoners by exploring how they are presented prior to committing the index offence, and how DSPD patients and prisoners have been handled at earlier decision-stages such as the point of sentencing. It is apparent that DSPD patients and prisoners do indeed carry a 'residue of prior handling decisions' (Hawkins, 1983b:17).

Chapter five also considers how DSPD patients and prisoners are presented as having responded to their detention prior to DSPD admission. By exploring the nature of their previous placements, records of adjudications, segregation, use of healthcare, and transfers to specialist facilities like Grendon, and the mental health system, the chapter considers the different ways that DSPD patients and prisoners are recorded as having responded to their previous detention. It exposes that previous classifications, such as a high PCL-R score, have the potential to affect a patient or prisoner's career, in that it can be used to exclude an individual from treatment programmes and/or admission to the mental health system. The chapter also considers how their dangerousness is evidenced and presented to the PB and MHRT, identifying the importance of interpretation and presentation of behaviour, because even seemingly positive characteristics like openness have the potential to be constructed by report writers as evidence of dangerousness.

Chapter six continues to explore the journey of DSPD patients and prisoners, following their admission to DSPD services. The chapter pays particular attention to how DSPD patients and prisoners are presented as having responded to their placement in DSPD and considers how any improvements in behaviour and/or continuation of disruptive behaviour is explained by report writers. The chapter identifies that DSPD report writers present DSPD placement as an appropriate and just response. This reminds us that

report writers are presenting not only DSPD patients and prisoners, but also the units and themselves. Chapter six also explores the importance of trust and engagement in DSPD therapy, and the significance of benchmarks and timetables for managing uncertain journeys through institutional settings.

Chapters seven and eight then consider what sense PB and MHRT decision-makers have made of the institutional careers of DSPD participants and their admission to a DSPD unit. The chapters identify that the presence of certain information, such as detention in a high security facility, can be taken by the PB and MHRT as evidence of high risk. It is also evident that the *source* rather than the *substance* of the data may be important for decision-makers, with PB and MHRT members most often placing their trust in institutional reports rather than those submitted by external 'experts'.

Chapters seven and eight identify that, as with DSPD patients and prisoners, and DSPD staff, PB and MHRT decision-makers also conceive the detention of DSPD participants in terms of a journey. The uncertainty that surrounds DSPD is argued to disrupt their conception of what a 'normal' journey through the criminal justice and mental health system should look like. Although the PB and MHRT were unlikely to recommend a progressive move, the reviews were found to serve other purposes. In this respect, a PB or MHRT review can play a significant role in confirming or challenging the institutional presentation of a participant's career.

## 5. The journeys of prisoners and patients prior to DSPD admission

*They have certainly injured their fellows, but perhaps society has unwittingly injured them (Glover, 1956:267 quoted in Pratt, 2007:388).*

### Introduction

This chapter explores how participants and their institutional careers prior to DSPD admission are presented to the PB and the MHRT. The notion of a 'journey' or 'career' is used to trace the legal and institutional criteria for admission to prison and hospital, and to consider where participants have been and how they have responded to various institutions before being transferred to DSPD. The participant's career could be considered to have three significant stages: first, presentation of the participant before conviction for the index offence; second, presentation of the participant in other institutions prior to DSPD admission; and finally, presentation of the participant following admission to DSPD. Drawing from the reports submitted to the PB and MHRT about prisoners and patients detained in the four high secure units for men, this chapter restricts itself to the first two stages, while the chapter that follows explores the presentation of participants following admission to DSPD. For ease of discussion, the chapter first considers the prisoners who gave consent to the study and then turns to consider the patients held in the hospital DSPD sites<sup>44</sup>.

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<sup>44</sup> In many respects this distinction is problematic because many patients had originally been given a criminal justice disposal and were originally 'prisoners'.

## **The journeys of DSPD prisoners prior to DSPD admission**

### ***The characteristics of DSPD prisoners***

Thirty-nine participants from the Fens Unit at HMP Whitemoor and twenty-seven from the Westgate Unit at HMP Frankland consented to take part in the study, of which thirty-five had fifty-two PB reviews since admission to DSPD and before 28 September 2007<sup>45</sup>. The youngest participant with experience of a PB review since admission to a DSPD unit was twenty-eight, while, the oldest prisoner was sixty-six. The average age of all participants was forty-three. It was difficult to confidently establish the ethnicity of all participants but the vast majority were classified as White British in line with the wider DSPD population, and previous research that has found that those with a primary diagnosis of personality disorder are most often white men (Cope and Ndgewa, 1990; Jones and Berry, 1984; Grounds et al 2004). Consistent details about marital status were not available, but few appeared to be married, with a large number of the sample classified as either single or divorced.

All of the participants had committed violent and/or sexual index offences including arson. Four of the thirty-five prisoners had been convicted of murder (2032, 2035, 4020, 4023), three of manslaughter by diminished responsibility (2020, 2024, 2056), four of attempted murder (2025, 2052, 2057, 4025), sixteen of rape or another serious sexual assault (2026, 2030, 2033, 2039, 2040, 2050, 2051, 2055, 2058, 4001, 4005, 4008, 4012, 4013, 4016, 4018), four of arson (2047, 2048, 4003, 4007), and four of a violent offence that did not appear to include a sexual element (2044, 2046, 4006, 4024). The majority of offences were considered to involve a sexual element or motivation, and amongst those convicted of sexual offences, many were also convicted of an offence of kidnapping and/or false imprisonment. The offences often involved unnecessary and perverse violence, highlighting research that has found an

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<sup>45</sup> This chapter and the thesis more generally restricts itself to the thirty-five prisoners who had experience of a PB review since admission to DSPD services.

association between high levels of psychopathy and increased sadism and violence during sexual offending (Gretton et al, 1994; Miller et al, 1994, both in Roberts and Coid, 2007; Quinsey et al, 1995).

Previous research has found that 'the image of the predatory stranger looms large in press discourse' (Greer, 2003:185). However, despite the public's association of violence with 'stranger danger', research has shown that we are all at more risk of being physically harmed, sexually assaulted and/or killed by those closest to us, with most victims and perpetrators known to each other (Walby and Allen, 2004). Indeed:

When most people think of violence, they think of an innocent victim attacked by a total stranger. The media exacerbate these fears by depicting the perpetrator as an unknown, unidentifiable psychopath that sneaks around hunting for prey ... The reality, though, is that the risk of dying at the hands of an acquaintance or family members far exceeds the threat of being killed by a complete stranger (Arrigo and Shipley, 2004:80).

Despite this observation, nineteen of the thirty-four prisoners had committed offences against strangers, three against people they hardly knew, two against both strangers and people known to them, seven against people known to them, while four prisoners were convicted of arson. In this respect, the majority of DSPD prisoners were the very 'unknown, unidentifiable psychopaths' that we most fear. Victims were both male and female, and although there were more female victims in the sample, nearly as many male victims were also found. Victims were of all ages, with the youngest victim only three years old, and the eldest, ninety-two. Three prisoners had committed sexual offences against children under sixteen, while five prisoners had committed serious violent or sexual crimes against those over the age of seventy-five.

Pre-sentence reports written by both probation officers and psychiatrists described a situation where nearly all the prisoners in the sample had a disruptive family history and many had experience of the care system. While in these disruptive environments, many had been subject to emotional, physical and sexual abuse by parents and carers. This highlights that in comparison to the general population, prisoners are far more likely to have grown up in 'care, poverty or an otherwise disadvantaged family' (Social Exclusion Unit, 2002:18). This is significant because those taken into care as a child, are likely to have longer prison careers (Social Exclusion Unit, 2002) and a higher incidence of personality disorder (Coid et al, 2006). The social services report for one prisoner at the time of sentencing captures the experience of many in the sample when it concludes:

2050 is an acutely vulnerable and unhappy young man who has spent nearly all his life in institutions of one sort or another. He has faced rejection from every quarter and now, resolutely accepts it as a fact of life (2050, 7(1) Social services report).

Reports made frequent reference to approved schools and low educational attainment, highlighting that thirty percent of male prisoners have a history of truancy from school and forty-nine percent have a record of exclusion from school (Social Exclusion Unit, 2002). Records of truancy and having been the victim of bullying were commonplace, and it appeared that very few left school with any qualifications. Once they had left school, few were found to sustain long periods of employment, with many dismissed for offences of dishonesty. This highlights that 'people with a personality disorder are far more likely to be unemployed or economically inactive' (Coid et al, 2006:430).

The majority of prisoners received into prison have a history of problematic alcohol and drug use (Social Exclusion Unit, 2002), and this was reflected in the histories of the

DSPD prisoners. Frequent references were made to the problematic use of drugs and alcohol, with many of the sample reported as being under the influence of drugs at the time of the offence.

Nearly all had extensive offending histories, often beginning from a young age. Although most already had a history of serious violent and sexual offending, the index offence most often signified an escalation in the seriousness of offending. This highlights that offenders with high psychopathy scores have been found to begin their criminal careers at an early age, and are responsible for a disproportionate amount of offending (Hare, 1981, Hare, 1983; Hare, 1998; Hart and Hare, 1997)<sup>46</sup>.

In addition to having spent large periods of time in the care system, many participants had spent time in young offender's institutions (YOIs) and/or prison, demonstrating the serious nature of some of their previous offending and the long time that many of them had spent in institutional care. A few were in the care of secure institutions at the time of their index offence, including 4007 who set fire to his room age fourteen in a secure children's establishment, 2057 who claims to have committed attempted murder in order to get himself removed from a high security hospital into prison, and 4008 who committed a robbery and sexual assault against a female member of staff at a medium secure hospital, allegedly to gain money to escape from hospital to kill his stepfather who had previously abused him.

### ***Getting into prison***

At the time of sentencing, Crown Court Judges have three broad options available to them. The first is a life or indeterminate sentence, with a minimum term or tariff that must be served before the prisoner's case can be reviewed by the PB. The second

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<sup>46</sup> This also highlights that many of the prisoners met the criteria for anti social personality disorder, which many consider to be a tautological diagnosis.



option is a determinate sentence, with a fixed period of time to be served. Depending on the length of the sentence, and now if they are considered 'dangerous' by the Sentencing Judge, their case may or may not be heard by the PB. The final broad option available to the Judge is a Hospital Order made under s37 of the MHA 1983, which can be 'restricted' for a specified or indeterminate period of time, thereby preventing the discharge of the patient from hospital without MHRT and/or the Secretary of State's recommendation<sup>47</sup>.

At the time of sentencing, the extremely disturbed nature of some of the index offences was raised by Sentencing Judges. During the sentencing of one prisoner convicted of kidnap and aggravated burglary, committed two days after a previous release from prison, the Judge described him as follows:

The defendant is a dangerous psychopath. Were he to be at liberty now there would be an obvious and serious danger to members of the public (2046, 6(3) Sentencing Judge).

In another case, of a nineteen year old man awaiting sentencing for the vaginal and anal rape of a ninety-two year old woman after he had broken into her house, the judge commented:

Words fail adequately to convey the horror that a person so young as you could behave in such an inhumane fashion against an elderly person ... your own counsel quite properly describes your conduct as inhuman, violent, a violation

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<sup>47</sup> This is a simplified account of the sentencing options available to Judges. Sections 35 to 38 of the MHA 1983 enable Judges to direct individuals awaiting conviction and/or sentencing to hospital for assessment and/or treatment. However, research has found that it is unusual for mentally disordered offenders to be transferred to the Special Hospitals while on remand (Kinsley, 1990) and that sections 36 and 38 are rarely used because of hospital admission policies and the unavailability of beds (Ashworth, 2000). It is of note that Ministry of Justice (2007a) guidance actually restricts the transfer of individuals with psychopathic disorder to hospital while on remand.

of her body, leading to physical degradation. He was right (4005, 2(1) Sentencing Judge).

While by no means exonerating this particular individual from responsibility for a very serious crime, the Judge goes on to observe:

Your background should bring shame to your parents, shame to the authorities who took you into care by way of protection from your parents' inadequacies and cruelty. But it seems that there is or was something in your character and make up which meant that you benefitted not at all from the assistance which the authorities tried to give you (4005, 2(1) Sentencing Judge).

This suggests that Judges make assessments of the reasons and responsibility behind the offences. In another case, for a man convicted of two rapes and intent to rob, the Judge observed:

The medical evidence, and it is voluminous, satisfies me that you are through no fault of your own mentally disordered. You are a violent psychopath and because of your illness there is a danger that unless you are confined for an indefinite period you will probably commit further grave offences (2050, 7(1) Sentencing Judge).

At the time of sentencing, many of the PB dossiers alluded to the difficulties in deciding about the appropriate disposal and treatment of offenders with personality disorder. Psychiatric assessments were commissioned for a number of the sample at the time of sentencing, but ultimately, all the prisoners were given a sentence of punishment, rather than a mental health disposal. Some prisoners had had psychiatric assessments at the time of sentencing, often identifying the presence of personality

disorder, but also identifying some of the problems surrounding treatability in the mental health system. One judge when sentencing a man for rape, aggravated burglary, indecent assault and possession of a firearm, commented:

I have most carefully considered the possibility here of a hospital order without limit of time, as your counsel has urged upon me ... and I am aware that a place is available for you ... but in my judgment it is not appropriate. The only appropriate sentence in this case is one of life imprisonment ... you must be detained until you cease to represent a risk to public safety; whether that time will ever come I do not know (2051, 1(1) Sentencing Judge).

Other judges made similar observations, often in line with the view of the psychiatrists. One psychiatrist writing about a man convicted of the false imprisonment and indecent assault of a female on a train commented:

2040 would not benefit from a disposal under the MHA, nor would such a mixed message regarding his personal responsibility assist him to overcome his own tendency towards denial or minimisation (2040, 4(2) Pre-sentence psychiatric report).

This demonstrates the increasing responsibilisation of people with personality disorder during the 1990s (Seddon, 2007) and the increasing pessimism amongst both the psychiatric and judicial professions about the treatability of those with personality disorder. This also highlights that offenders with personality disorder are most commonly dealt with by the criminal justice system (Coid, 1991, 1998) and found in prison (Gunn et al 1991), with sixty-four percent of sentenced male prisoners meeting the criteria for personality disorder (Singleton et al. 1998, see also Fazel and Danesh,

2002)<sup>48</sup>. Another psychiatrist, writing at the time of sentencing for a prisoner who had been convicted of the attempted rape of a seventy-eight year old woman, summarises some of the dilemmas:

The treatment of psychopathic disorder is primarily psychological in nature. It requires a degree of openness and honesty on the part of the patient. It also requires that the patient has some insight into their problems and expresses a real willingness to change. There is also the expectation that the patient is able to acknowledge their problems and discuss them openly and frankly with the therapist. 2058 in my opinion has minimised his offending behaviour and does not, by his own account see himself as a sex offender. He sees his sexual offending as being sudden, transient urges that come upon him for no apparent reason. With such a position it is difficult to see how any therapist could work usefully on addressing these problems with this man (2058, 4(1), Pre-sentence psychiatric report).

This statement highlights an important observation in regard to the treatment of offenders:

An enduring irony (if not contradiction) of treatment is that much of its success depends on the honesty of the dishonest, and in particular on the dishonest becoming honest prior to and as a precondition of treatment not as a consequence of it (Grant, 1999:101).

While most of the prisoner sample were identified as suffering from personality disorder at the time of sentencing, few, even those with previous contact with the mental health

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<sup>48</sup> The presence of personality disorder amongst the prison population is not wholly clear due to the variety of criteria and methodologies used in the minimal research that has been done (see Gunn et al, 1991; Dell et al, 1991).

system were identified as suffering with other mental illness. The behaviour and judicial response for one prisoner who was transferred to Broadmoor on remand for assessment, however was reported as follows:

Reported to be “floridly psychotic” ... thought that people in the street were staring at him as if they knew he was an ex Broadmoor patient ... experienced people touching his face, buttocks and other parts and he had to slap himself to stop this. He had a vision of Jesus he heard people talking about him and was convinced that people were spitting in his food. He heard voices telling him to kill his mother and believed that the number 7 was highly significant ... was treated vigorously with antipsychotic medication but only slowly responded to this ... less aggressive than in prison but there were still some difficulties with assaults, threats and intimidation ... recommendation was made to the court that he should be further detained in hospital under s37/41. However at court he was sentenced to 5 terms of life imprisonment ... soon after sentence he was placed ... in the healthcare centre (2051, 1(1) Psychiatrist report).

In this case, the reports at the time of sentencing suggest that the man was clearly ill. Yet he was still refused a hospital bed. This highlights the tension that exists between punishment and treatment for offenders considered to be dangerous and/or personality disordered. It is apparent that detention in the mental health system is not regarded as adequate punishment or good enough to protect the public. The mental health system was also dismissed on the basis that it would foster institutionalisation, and that it was not a good use of resources. In deliberating about the possibility of a hospital placement for a man convicted of kidnapping and aggravated burglary, one Judge commented:

It is just as likely that the treatment may come really to the end of the road and nothing more can be done for the defendant and he would remain in a secure hospital for want of anywhere else where he could be sent consistently with the purposes of safety. It seems to me that that is not a good use of the very, very scarce resources of the secure hospitals (2046, 6(3) Summary of progress in prison).

In addition to the debate that surrounded a prison or hospital placement, some debate centered around the merits of an indeterminate sentence or a long determinate sentence for a few of the participants. Some of the dilemmas raised by determinate sentences, and the significance of this for the journeys that prisoners make in the prison system, was outlined in one of the pre-sentence reports for a man convicted of three rapes:

I am therefore focusing on the merits of a determinate or indeterminate sentence. It is the experience of those working with prisoners serving a determinate sentence, for very serious offences, that they can easily blend into the prison system. Contact with psychology or psychiatry is not routinely available, all too often little or no work may be done which enables the prisoner to fully understand and accept the offence. Although risk assessments are carried out during parole reviews, the prisoner may well be released with little supervision. This has far reaching consequences for the protection of the public. I am drawn to the conclusion that in this case, there can be little chance of ensuring long-term public protection without the imposition of a life sentence. I acknowledge that this is an unusual conclusion to draw, however I cannot see that a determinate sentence will achieve the necessary focus on monitoring behaviour change (2055, 3(3) Pre-sentence probation report).

### ***The traditional prison journey***

Information regarding how prisoners should move through the prison system is outlined in Prison Service guidance. While several studies have considered how prisoners may adapt and respond to imprisonment, there is very little research that considers how, in practice, prisoners actually travel through the prison system. One exception may be found in Adler and Longhurst's (1994) study of the importance of classification decisions and prisoner careers in the management of long term prisoners in Scotland. They argued that institutional discourses about what prisons are for, and how they should be run, have important effects on decision-making about prisoners and their institutional careers (ibid).

Once a life sentence prisoner has been convicted and sentenced, their security category and Main Centre Allocation (MCA) must be determined. The system of security categorisation was introduced following the Mountbatten Report into Prison Escapes and Security (Home Office, 1966), and classifies prisoners according to their perceived risk. Prisoners are classified: A, those 'whose escape would be highly dangerous to the public or the police or the security of the state'; B, those 'for whom escape must be made very difficult'; C, those 'who cannot be trusted in open conditions'; and D, those 'who can be reasonably trusted in open conditions' (PSO 0900, Categorisation and Allocation).

Custody level assignments are important to consider as they can be viewed as correctional systems' generalised response to risk (Porporino and Motuik, 1995) and are at 'the heart of prison management' (Home Office, 1984: para 85). Security categories affect many other significant decisions in the Prison Service, including subsequent decisions about recategorisation, which, like the original categorisation decision, are often arbitrary and marked by confusion (Price, 2000). Security

classification has also been considered to have an impact on a prisoner's career (King and McDermott, 1995), and significantly it:

is perhaps the most important internal procedure that the Prison Service has. It structures the use of the prison estate ... Almost every other internal procedure within the system is conditional on the results of one decision. Yet the procedure operates in relative obscurity, opacity and with a quiet power greater than any other policy within the prison system (Price, 2000:3).

Section 4.1.1 of the Lifer Manual (PSO 4700) outlines the expected pathway of life sentence prisoners through the Prison Service. Prisons are categorised by their security levels and function (Reed, 2002). Life sentence prisoners are first located at a remand centre or a local prison. Within six months of their sentence it is expected that prisoners will then move to their MCA, a First Stage Prison. Most life sentence prisoners will move to one of five high security<sup>49</sup> or category B First Stage prisons. Once they are considered suitable, prisoners can then be transferred to a Second Stage prison, which can be as low a security category as Category C. The third, and final stage before a prisoner will be considered for release on license is a Category D prison, also commonly referred to as an 'open' or 'resettlement' prison (PSO 4700, Lifer Manual).

On arrival to their First Stage prison, it is expected that prisoners will complete a Life Sentence Plan (LSP) (PSO 4700, Thornton, 2007). LSPs were first introduced in 1993, although they have been revised in 2001 (when F75 reports were replaced) and more recently in 2008 (to incorporate IPP sentence prisoners). The purpose of LSPs is:

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<sup>49</sup> High security prisons are often referred to as dispersal prisons. The concept of dispersal prisons followed the Mountbatten report (1966) and the need to separate the most dangerous prisoners. There are currently eight high security / dispersal prisons in England and Wales.



to plan, monitor and record the means by which each lifer is supported in the process of achieving a reduction in risk during sentence such that he or she may safely be released on license into the community at tariff expiry (PSO 4700, Ch8:1).

LSPs are important for structuring the prisoner's career through the prison system, and should be reviewed annually. It is usually the case that life sentence prisoners will not be able to progress beyond Category B conditions until they have addressed their offending behaviour (Harris, 1991 in Stone, 2008:38). Prisoners should also not expect a transfer to open conditions until they have had their first formal PB review, and for those assessed as having to take the Sex Offenders Treatment Programme (SOTP), until this has been completed (Stone, 2008). However, the Social Exclusion Unit (2002:40) identifies that decisions are often based on resources rather than needs, and while:

sentence planning should be the cornerstone of work to tackle re-offending in prison ... too often it is a paper exercise of which prisoners are barely aware, or that is used to allocate prisoners to what is available rather than what they need.

Prisoners are also classified in other ways during their prison careers, which may impact on how PB members interpret the progress that they have made. The Incentives and Earned Privileges (IEP) scheme<sup>50</sup> was introduced in 1995 following the Woolf report (1991) into the prison riots at Strangeways prison. The IEP operates at three levels; basic, standard and enhanced and affects the privileges to which a prisoner is entitled, including money, work and visits. More recently another incentive

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<sup>50</sup> See Liebling et al (1999) for further discussion

scheme, the Good Lives and Development (GLAD),<sup>51</sup> based on the Good Lives Model (GLM) (see Ward, 2002; Ward and Brown, 2004; Ward and Stewart, 2003) has been introduced to the prison estate, including the Westgate DSPD unit at HMP Frankland.

### ***The journeys of DSPD prisoners***

All of the prisoners in the sample were sentenced between 1980 and 2002 before the Criminal Justice Act 2003 came into force. The majority of participants (n=33) were given a life sentence<sup>52</sup>. The minimum term, or tariff, set for life sentence prisoners varied enormously with the lowest set at three years (4007) and the highest set at eighteen years (2032). On average, the length of tariff was about eight and a half years<sup>53</sup>.

The remaining two prisoners in the sample were serving a determinate sentence. These prisoners had been given a two and a half year (2025) and an eight year (2044) sentence, although one of these participants was given several additional determinate sentences, and finally an IPP sentence for crimes committed while in prison, thereby making his legal status more complex. It is unfortunate that detailed records were harder to access for the determinate sentence prisoners, so the data regarding DSPD prisoners are predominantly based on the experience of life sentence prisoners.

The prisoners had a variety of institutional careers prior to DSPD admission. Participants were at all stages of their sentence, with some undergoing their first pre-tariff PB review, and others experiencing their tenth PB review. This demonstrates that some prisoners were still in the earlier stages of their sentence, while others were as

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<sup>51</sup> See Fox (2008) for further discussion

<sup>52</sup> For an overview of life sentences pre CJA 2003 and their significance for parole see Padfield (2002). See Stone (2008) for overview post CJA 2003.

<sup>53</sup> See Stone (2008) for an overview of how tariff setting has changed. Today the minimum term for mandatory lifers is set by the trial judge in open court at the time of sentencing under the provisions of Section 269 and Schedule 21 of the Criminal Justice Act 2003.

many as twenty years over tariff. Since the time of their sentence, prisoners had served an average of fourteen and a half years in prison, ranging from between five years and two months to twenty-seven years and seven months.

The MCA for twenty-two of the thirty-five prisoners was one of the eight high security prisons, while eight prisoners had been allocated to Category B conditions. Three of the remaining five prisoners were transferred to Young Offenders Institutions, while the MCA for two prisoners was unknown. At the time of transfer into DSPD services, thirty-one of the thirty-five prisoners had been transferred from elsewhere in the high security estate; two from Category B prisons; one from Broadmoor Hospital DSPD unit, and one unknown. This highlights that during their sentence prior to DSPD many prisoners had moved up the security ladder, rather than follow the expected pathway through the different security categories.

At the time of their last review, twelve participants were Category A prisoners, and twenty-three were Category B. Despite the importance of security classification for a prisoner's journey through the prison system, information was difficult to locate. The records for a few Category B prisoners suggest that they had originally been categorised as Category A but at some point prior to DSPD admission had been downgraded. One participant was also originally categorised as Category B, but then re-categorised to Category A, before being downgraded again.

### ***Dangerous and disruptive journeys***

Previous research has suggested that up to five percent of prisoners are disruptive and dangerous while in prison (Coyle, 1987). While difficulties exist in determining what is meant by 'disruptive' and 'dangerous', it is of note that far more than five percent of the sample discussed here were presented as displaying these types of behaviour during their prison careers. This is an important observation because it is likely to have an

impact on how they are known, reported on, and how decisions are made about them by the PB.

The majority of prisoners were described as having had turbulent prison careers, and for many, especially in the earlier stages of their sentence, a record of adjudications was common. Adjudications are internal disciplinary hearings following a breach of the prison rules<sup>54</sup>. Adjudications were given for a wide range of offences including using threatening words and behaviour (2040, 4007), possession of hooch or other unauthorised items including drugs (2040, 4020), setting fires (4007), destroying prison property (4007, 4008), assaults on other prisoners or staff (2057), fighting (4007, 4008, 4020), and other minor infractions including failure to work/follow orders (4008). Adjudications had led some participants to receive additional days awarded (ADAs), with one determinate prisoner (2025) given nearly a year's worth of ADAs to his original sentence<sup>55</sup>.

Under Rule 45(1) of the Prison Rules 1999 and where 'it appears desirable, for the maintenance of good order or discipline or in his own interests, that a prisoner should not associate with other prisoners', the prison governor can arrange for prisoners to be removed from normal location to segregation. Most of the prisoners had been in and out of segregation following problematic behaviour (2025, 2030, 2032, 2033, 2039, 2040, 2044, 2046, 2047, 2048, 2051, 2052, 2055, 2056, 2057, 4005, 4007, 4012, 4018, 4023), and many reasons could be found for the use of segregation. These included: sexual assaults on other prisoners (2039); physical assaults against both staff and other prisoners (2057); threats to kill (2040, 2046, 2051); being found in possession of home made knives (2056) and fighting (2055, 2056). A few prisoners were reported to

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<sup>54</sup> See PSO 2000 Adjudications for more information.

<sup>55</sup> The system of adjudications has changed following a 15 July 2002 judgment that found the system of adjudications to be unlawful under ECHR. See *Ezeh and Connors v UK* (39665/98; 40086/98) [2002] 35 EHRR 28.

have threatened (2040) plotted (2048) or actually carried out hostage incidents (2035, 2046, 2052, 4023). This highlights previous research that has found that offenders with higher psychopathy scores are more likely to be involved with fights in prison (Hare and McPherson, 1984; Hare and Hart, 1993; Hart and Hare, 1997) and to be segregated (Coid et al, 2003; McCord, 1982; Reiss et al, 1999). A review by Coid et al (2003:298) found that:

[s]egregated prisoners were more likely to be younger, with histories of violent offending, career criminality, early environmental disadvantage, anti-social personality disorder, drug misuse – specifically crack cocaine – and higher scores of psychopathy.

Many of the prisoners had experienced several transfers across the prison estate<sup>56</sup>. Transfers around the prison estate are problematic because they add to the challenges involved with knowing the prisoners. Reasons for transfers amongst the sample were not always clear from the PB dossier, reflecting the diversity of reasons behind prison transfers, and the fact that data about prison transfers are not held centrally and are particularly difficult to locate (Social Exclusion Unit, 2002). Research has found that prisoners often experience several transfers during their time in prison (HMIP, 2001) and these can occur for a number of reasons including:

overcrowding; progression to more open conditions (or vice-versa); access to a particular course or programme; to return nearer home for the last part of their sentence to aid resettlement; and to maintain good order and discipline (Social Exclusion Unit, 2002:34).

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<sup>56</sup> See Martin (2000:218) who notes that despite the criticism in the Woolf Report (1991) about the practice of frequently moving prisoners around the prison estate in a practice known as 'the ghost train', 'magic roundabout' or the 'shared misery circuit', the practice still remains.

When reasons for transfers could be identified they ranged from: coming off Rule 45 to return to normal location (2020, 2024, 2047, 2048); for becoming over familiar with female staff (2020); for threatening other prisoners and other breaches of discipline (2030, 2048); to be placed on a Vulnerable Prisoners Unit (VPU) for their own protection (2024); to separate prisoners (2039); to undertake offending behaviour work (2033, 2047); for refusing to undertake offending related work (2035); to facilitate family visits (2047); in response to escape attempts (2048); following psychological concerns (4005); and to facilitate transfer to the mental health system (2048). The psychiatry report for one prisoner with numerous transfers and a particularly disruptive early prison career notes that he:

moved to HMP Wakefield but after only a short time on normal location was moved to the segregation unit after making threats to kill ... wrote letters to Prince Charles and Mrs Thatcher threatening to torture and kill them ... remained in segregation for 16 months ... took a third prisoner hostage in the segregation unit exercise yard ... shortly after the hostage incident 2035 was transferred to HMP Parkhurst ... placed in C wing (special unit) ... transferred to Rampton ... remained there for about four months .... changed his mind a number of times about whether he wanted to stay in hospital or return to prison ... hit a member of staff ... on his return to HMP Parkhurst he was placed in hospital wing ... transferred to Rampton .... During the course of the admission 2035 attempted to strangle another patient ... also attempted to stab another patient ... requested return to prison ... placed at HMP Full Sutton ... then transferred to HMP Whitemoor ... when I first met him ... he was very uncertain as to whether he wished to undertake DSPD assessment (2035, 3(1) Psychiatrist report).

This psychiatrist report highlights that this prisoner, like four others, had spent time in one or more Control Review Committee (CRC) special units like the ones previously based at Parkhurst, Lincoln and Hull (2032, 2033, 2035, 2046, 4023)<sup>57</sup>. That some participants had spent time in one of the CRC units is unsurprising given previous research that has identified seventy-three percent of men in the special units scored thirty or more on the PCL-R (Coid, 1996 in Coid, 1998, see also Coid, 1991). In part this illustrates that offenders with personality disorder have been presented as synonymous with difficult and unmanageable populations and that specialist placements like CRCs have been used, and regarded as 'storing houses' for those with personality disorder.

Several prisoners who were unpredictable in the early stages of their sentence were depicted as particularly high risk and motivated to establish an image of dangerousness. A psychiatry report for one prisoner identified that he:

wanted to be seen as '100% evil, the worst person ever, so all are afraid of me' (2047, 4(1) Summary of progress in prison).

The reports of another prisoner noted that:

he seemed to want to reinforce his dangerous image, and said he would kill someone one day ... he seemed proud that he had been identified as a psychopath (2046, 6(3) Summary of progress in prison).

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<sup>57</sup> CRC units were replaced in 1998 with Closed Supervision Centres (CSCs). For a review of CRCs see Bottomley and Hays (1991) and Bottomley (1995). For an overview of CSCs see Clare and Bottomley, (2001). Of recent note is that on 14 Oct 2008 Mr Hanson, in the House of Commons (Column 1030W) reported that: 'investment (£308 million in 2006-07 and £336 million in 2007-08) is also being made in four close supervision centres (CSC) at Whitemoor, Wakefield, Woodhill and Long Lartin prisons to deliver mental health care to those prisoners whose offending behaviour and history mean that containment in secure isolated accommodation is the only option'.

Rather than deny their offending behaviour, as many prisoners are found to do, some appeared to enjoy openly talking about their offences, and to display particularly disturbing and dangerous attitudes. The summary of progress report for one man convicted of the rape, kidnap and buggery of two eleven year old children, begins:

Early reports described 2039 as a dangerous masochistic child molester who appeared to enjoy relating his past experiences of beatings to staff. Staff reported that he would openly admit to having masturbatory fantasies of beating young children and enjoyed the notoriety of his category A status. Staff described him as possibly one of the most dangerous prisoners in the establishment (2039, 3(1) Summary of progress in prison).

While some prisoners were presented as having revelled in openly talking about their index offence and related fantasies, in contrast some prisoners were presented as withdrawn and particularly difficult to know. In the early stages of their sentence, frequent reference was made to high rates of denial, 'minimisation' and a 'lack of empathy' in the PB dossiers. Often prisoners blamed their use of alcohol/drugs and other background factors, including their upbringing, for their subsequent offending behaviour. Prisoners were also recorded as blaming the victims and the police for their offences. This demonstrates that both the behaviour and attitude of DSPD prisoners is depicted as dangerous, and that both openness and denial can be regarded as evidence of ongoing risk. This suggests that the choices that DSPD prisoners make about whether they wish to be known or remain unknown can have an important impact on the assessments made about their risk and willingness to change.

A small number of prisoners engaged with appeals of either their conviction or sentence. This highlights research by Sapsford (1983:88) who found that a small number of life sentence prisoners became preoccupied with appeals. This was



problematic because, like transfers around the prison estate, it helps prevent the completion of offending behaviour work, and is another reason for delay. The problems raised by this were well summarised in the post-sentence report for one prisoner convicted of the murder of a 78 year old man:

2032 is a very difficult person to get to know, he is suspicious of authority and has already clashed several times with prison authorities, resulting in transfer and disciplinary action ... he has appealed against the conviction which has pre-empted discussion over the offence and his attitudes towards it, creating an atmosphere of uncertainty (2032, 3(1) Post-sentence report).

### ***Vulnerable and hidden journeys***

Other people who were difficult to know were those who also ended up in segregation, healthcare or a Vulnerable Prisoners Unit (VPU). While segregation was often invoked following the disruptive behaviour of inmates, it was also used to protect prisoners from other prisoners. This usually followed from: getting into debt from gambling or drugs (2020, 2024, 4020); fears of being attacked by other prisoners (4005); plans to take them hostage being unveiled (4012); because of the media attention that their offence had generated (2030); or following threats of self harm and or suicidal ideation (2047, 2052, 4005).

Several prisoners had been transferred around the prison estate for their own protection, and a number were recorded as having been located on VPUs (2020, 2024, 2026, 2030, 2032, 2047, 2048, 4025). VPUs are separate units within a prison most used to house vulnerable prisoners. They are most commonly associated with housing sex offenders in order to protect them from other prisoners in the general population. In contrast to the traditional separation of sex offenders from non-sex offenders in the

prison estate, both groups are expected to live, and complete treatment together, on a DSPD unit.

Some prisoners were also reported to have spent considerable time in the healthcare wing of the prisons in which they were located (2035, 2046, 2047, 2050, 2057, 4023). While on healthcare units prisoners are unlikely to be able to engage in offending behaviour work, which may lead to them being increasingly unknown and misunderstood by staff on normal location. The reports of one prisoner convicted of arson noted that:

despite the best efforts of staff, 2047 had isolated himself and resisted efforts to persuade him to return to the wing (from the Health Centre). It was felt that until he returned to normal location no offending work could be undertaken ... efforts to move 2047 led to deliberate self harm and threats that he would kill himself (2047, 4(1) Summary of progress in prison).

Many prisoners were reported as having isolated themselves from the rest of their peer group. While this illustrates that some long term prisoners learn how to avoid becoming involved in difficult behaviour and choose to associate with a small number of their peers (Zamble, 1992 in Stone, 2008:59), their withdrawal and isolation was still reported by report writers as problematic. This may be the result of their withdrawal limiting the opportunities for them to become known. While DSPD prisoners may have been well known for their disruptive or disturbed presentation, by spending time away from normal location in segregation, healthcare or VPUs, they are also presented as a group that the Prison Service has struggled to know.

### ***Stable journeys***

The majority of prisoners of course, do conform to the prison rules and complete their sentence without event (Coid et al, 2003). Some, but certainly not the majority of DSPD prisoners, were reported as having relatively stable prison careers, often settling into a small number of institutions after their sentence (2020, 2024, 2030, 2055, 2056, 2058). Often these prisoners were without a record of adjudications and time on segregation, and if they did have a record, it was most often very early in their sentence.

However, despite their presentation as well behaved, they were most often identified as having completed little or no offending behaviour work. When offending behaviour work had been completed, scepticism about the progress made, and the prisoner's motivation for engaging, can be discerned. One prisoner, despite having a consistently positive record of prison behaviour, was described in the summary of progress reports as 'quick to learn the right answers and present the image of someone coming to some understanding of himself' (2020, 8(1) Summary of progress in prison). Later in the report it was noted that:

his institutional behaviour has remained excellent and he has made positive use of the facilities provided. Reporting officers were however doubtful as to how much of his views were genuine and how much were simply a direct regurgitation of views expressed by the professional (2020, 8(1) Summary of progress in prison).

This demonstrates the double bind that prisoners may find themselves in, and that seemingly positive behaviour can be treated with scepticism and interpreted as evidence of manipulation. A presentation as knowable and unknowable can both be interpreted by prison staff as problematic. DSPD prisoners who had previously

engaged in treatment are often treated with some considerable scepticism despite their presentation as willing for the authorities to know them. This may have important implications for engagement as prisoners may feel that they are damned if they do and damned if they do not. The problem of course is that:

[p]sychopaths are often seen to work the system to their own advantage and are exceptionally skilled at securing conditional release from prison, despite their lengthy criminal histories and sometimes a history of previously violating conditions of release (Hobson and Shine, 1998:504; see also Porter et al, 2009).

### ***Treatment journeys***

First introduced in 1992, and further encouraged following McGuire's (1995) "what works" principles, a number of offending behaviour programmes, defined as 'a systematic, reproducible set of activities in which offenders can participate' (Debidin and Lovbakke, 2005), are offered within the Prison Service. Accreditation is given by the Correctional Services Accreditation Panel (CSAP), and in April 2004, the Prison Service offered nineteen fully or provisionally accredited programmes across 112 out of 137 prisons (Arnold and Creighton, 2006). These include: Enhanced Thinking Skills (ETS); Controlling Anger and Learning to Manage it (CALM); Sex Offender Treatment Programme (SOTP); Healthy Sexual Functioning (HSF); Healthy Relationships Programmes (HRP); Counselling, Assessment and Throughcare Services (CARATS) and Chromis (a programme that aims to reduce violence in high risk offenders whose psychopathic traits are considered to disrupt their ability to accept treatment and change). In addition there are two accredited therapeutic communities at HMP Grendon and HMP Dovegate (Debidin and Lovbakke, 2005).

References to the SOTP and other accredited offending behaviour programmes including ETS were commonplace in many of the PB dossiers. Participants were often assessed as unsuitable for accredited offending behaviour programmes, because of a high PCL-R score (2020, 2040, 2050, 2056, 4007, 4013, 4020). The dossier for one prisoner suggested that his previous diagnosis of personality disorder had 'allowed others to evade responsibility'; thereby leaving him in a 'limbo' position (4007, 6(1) Summary of progress in prison).

Other reasons for not allowing prisoners to engage with offending behaviour work included their young age, following assessment that they were unlikely to benefit, and because of their denial of responsibility for the index offence. One particularly institutionalised participant (4007) who had been in the care system since age ten, and youth custody since age fourteen, was not recommended for offending behaviour work on the basis of his immaturity and the need for him to demonstrate a period of stable institutional behaviour before it would be appropriate.

Several who had been able to participate in offending behaviour courses were then deselected. Reasons for deselection included: being unable to cope in terms of emotional instability (2033); denial of the sexual elements to their offending (2048, 2050); unreasonable behaviour (4001); breaking group confidentiality (4013); and because of their 'interpersonal style and apparent difficulty working within a structured treatment programme, possibly due to concentration issues' (2030). The non-completion of treatment highlights that high levels of psychopathy have been associated with programme dropout (Attrill et al. 2003 in Cann et al, 2003).

Some prisoners (2032, 2046, 4005) were reported to have particular difficulties trusting staff and other prisoners in therapy. Many were reported to have been particularly distressed in group therapy, especially those who had experienced sexual abuse as a

child. A number of prisoners had simply refused to take part in either assessment or the treatment. Others were reported as saying that they 'can't be bothered to jump through hoops' because they did not 'trust the system' (2033, 5(3) Home probation officer report). The reports of one prisoner, who wished to have no contact with his four children on the basis that he 'saw no prospect of release', was also noted as having:

reported that he had not undertaken any offending behaviour programmes as of yet. He stated that he did not want people to know a lot about him until he felt ready to do so (2052, 2(2) Summary of progress in prison).

This highlights that while many of the sample had been denied access to key courses, when the opportunities to undertake offending behaviour programmes had been made available, many did not wish to take part. This is a situation previously observed with segregated prisoners, in that they:

appeared to have a more negative view of receiving psychiatric treatment in prison since they were more likely to say that it had been denied to them and they were also more likely to admit that they had declined to see a professional for treatment when the opportunity had been offered to them (Coid et al, 2003:315).

Concerns about the lack of progress made in various offending behaviour programmes were commonplace in the reports. When DSPD participants had previously been able to complete the SOTP or other key offending behaviour work, doubts about its success were often raised (2030, 2040, 2058, 4005). Doubts about the effectiveness of treatment often led to recommendations for participants to repeat or complete similar courses, including the Extended/Adapted SOTP.

Doubts about the effectiveness of the courses like the SOTP, have centred around anxieties that treatment has the potential to increase the risk that personality disordered offenders pose, and help them to become 'better psychopaths' (see Morris, 2004b for discussion, and D'Silva et al, 2004 for a review of the evidence). In this respect, enabling prisoners to know more about themselves through treatment is presented as dangerous. The summary of progress for 2024 notes that:

he had co-operated to the extent that he had recently completed a Sex Offender Treatment Programme (SOTP). Unfortunately on the available evidence, after his participation in this programme, the risk he presented to the public had increased rather than decreased (2024, 3(2) Summary of progress in prison).

Another prisoner, was assessed as not suitable for core offending behaviour work on the basis of his dangerousness, concerns that '1:1 work could lead to a grave situation for the interviewer' and anxiety that SOTP 'would fuel his erotic fantasies and generally have a detrimental effect on other group members' (2039, 3(1) Summary of progress in prison). At a later establishment it was noted that due to the lack of insight and empathy towards his offence, 'staff felt that it was unlikely that he would ever attend any such group and failed to see how he would benefit if he did start' (2039, 3(1) Summary of progress in prison). This demonstrates how characterisations can follow a prisoner through his prison career, and that knowing more about offenders through treatment has often been viewed as potentially dangerous.

One alternative to participation in offending behaviour programmes are Therapeutic Communities (TC)<sup>58</sup>. Currently five democratic therapeutic communities are available for male prisoners; two of which have been accredited. The most established and well

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<sup>58</sup> See Cullen et al (1997) for more information

known TC in the Prison Service is HMP Grendon which offers 235 places for Category B and C prisoners. Several prisoners were recorded as wishing to go to Grendon, recommended for a place, or having been assessed and rejected (2032, 2033, 2040, 2047, 2050, 2052, 2055, 2056, 4007, 4012, 4018, 4020, 4023).

For the small number of participants who did receive a transfer to a specialist TC like Grendon (2020, 2030, 2046, 2048, 2058) information about the prisoner's experience, and the reasons for a transfer to, and back from the TC, were not always clear from the PB dossier. This demonstrates that the transfer of prisoners around the prison estate often leaves many gaps in knowledge about who they are. Where reasons were available it transpired that participants had been voted out by the community or removed because of inappropriate behaviour towards female staff (2020), threats to other prisoners and staff (2030, 2058), being considered to lack the motivation or ability to engage in group therapy (2048, 2058) or because they chose to opt out of treatment (2046).

A few prisoners in the sample had been transferred to hospital under the MHA 1983 (2033, 2046, 2048, 4007, 4016). While several had been assessed, the majority, for reasons unknown from the reports, had not been offered a bed. Of those who had been transferred to the mental health system, some reasons could be identified for their return to the Prison Service. These included the assault of other patients (4007, 4016) and refusing to co-operate with treatment (2046, 2048). One patient initially settled, but within:

a few months, his motivation seemed to decline and his behaviour became increasingly disruptive with threats towards other patients, confrontational behaviour in groups, racist comments to staff and general lack of engagement with the programme (2033, 5(3) Psychiatrist report).



Another individual (2048) was transferred to hospital under s47/49 of the MHA 1983 but was soon transferred back to prison after absconding from the unit. Later 2048 was transferred to a high security hospital for another opportunity at treatment in the mental health system, but was removed because he 'had progressively withdrawn from all psychological treatments and had also threatened to kill 2 other patients on the ward' (2048, 10(1) Summary of progress in prison).

These institutional records suggest that DSPD participants have often been given specialist placements, but for whatever reason, have not taken advantage of the opportunities provided to them. This may be unsurprising given the double-bind that many prisoners appear to find themselves in. It is evident that many DSPD participants have struggled to place their trust in treatment and the system, which may be understandable when one considers that the system, especially in regard to the treatment of personality disorder, gives them few guarantees. The potential of treatment is largely unknown to staff and prisoners, and requires some considerable trust and openness on both sides to enable participation and completion. Given that many prisoners are treated with scepticism when they have opened up to treatment and enabled the potential for others to know them and to develop knowledge of themselves, it is unsurprising that some may adopt a protective stance and engage in many counter-therapeutic behaviours.

## **The journeys of DSPD patients prior to DSPD admission**

### ***The characteristics of DSPD patients***

Twenty-five participants from Broadmoor and twenty-one from Rampton gave their consent to the study. Of these forty-six patients, twenty-four had twenty-eight MHRT since admission to DSPD<sup>59</sup>. It is of note that the DSPD patients had very similar

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<sup>59</sup> As with the prisoner sample, this chapter and the thesis more generally, restricts itself to the twenty-four patients with experience of a MHRT review since DSPD admission only.

demographic characteristics to the DSPD prisoners (see Table 3). The age range of patients ranged from twenty-five to fifty-six with an average age of thirty-seven. In terms of ethnicity, all but two participants were classified as White British, with the remaining two classified as White Irish, and simply British. This is in line with previous research that has identified that Black individuals are rarely detained under the legal classification of psychopathic disorder (Cope and Ndgewa, 1990; Jones and Berry, 1984; Grounds et al 2004), despite being found at higher and disproportionate rates for mental illness. According to the hospital records the marital status of twenty of the participants was classified as single while three were recorded as divorced, and one was unknown. This supports previous research that has found that patients with personality disorder were more likely to be single than those with mental illness (Coid et al, 1999).

The index offences varied with one patient convicted of murder (1019), two of manslaughter (1010, 3015), one for attempted murder (3002), ten for a sexual offence, most often indecent assault although a few had been convicted of rape (1001, 1005, 1008, 1013, 1015, 1016, 1018, 3003, 3010, 3017), one for arson (3028), and nine for violent offences that did not appear to be sexually motivated (1006, 1020, 1022, 3004, 3016, 3020, 3023, 3024, 3030). What was perhaps notable about the patient sample in comparison to the prisoner sample was that the sexual and violent offences were more difficult to neatly categorise, with many convicted of less serious offences that didn't necessarily attract a life sentence.

Fifteen of the twenty-four patients had committed offences against strangers, while nine offended against people known to them. Like the prisoners, the patients go against what we know about 'normal' offending in that they had committed more offences against strangers, thereby adding to anxieties about their dangerousness. Victims were both male and female, with at least half of the sample having offended

against men. Like the prisoner sample, many of these offences had been sexually motivated. The age of victims was harder to reliably determine from the reports, but like the prisoner sample, victims ranged from children through to the elderly. At least eight of the participants had offended against children under the age of sixteen; a higher proportion when compared to the prisoner sample. Given that the differences between DSPD prisoners and patients are minimal, and that a number of the patients have been sectioned under mental health legislation towards the end of their prison sentence, it may be of note that a higher number of DSPD patients had sexually offended against children.

The MHRT reports devoted far more time than the PB reports to the family and personal history of the patient before conviction. Like the prisoner sample, the patients had often experienced a particularly disruptive childhood and adolescence. Often, father figures were absent during the patient's childhood and adolescence for a variety of reasons, ranging from them having left the family, often worked away from home, being sent to prison, or having died. Several of the records suggested that the mother (and father when he was around) could not cope with the escalating behaviour and disruption of the child. Often, either because there was concern that the parents could not cope or that they were neglecting/abusing the child, the child ended up in local authority care. Once in care, several records made reference to allegations of physical and sexual abuse.

Similarly to the individuals in the prisoner sample, many patients were recorded as having disruptive schooling careers, characterised by records of exclusion and transfers to special needs or boarding schools. Being the victim of bullying was reported as a common experience for many, with some patients described as increasingly withdrawn during their childhood and adolescence. Once they had left, or been excluded from school, few were recorded as having a stable record of

employment. Often, employment had been disrupted by dismissal or criminal conviction.

While records of the misuse of drugs and alcohol were not always clear from the reports, at least half of the participants had a record of problematic alcohol use. Several patients also had a record of problematic drug use, varying from the use of cannabis, through to class A drugs including cocaine and heroin.

Most of the patients had a lengthy previous criminal record. Their offending histories varied in seriousness, and often were not as serious or extensive as the prisoner sample. Several participants had a history of cruelty to animals and fire setting from an early age. A number of patients had spent time in YOIs, prisons, and as inpatients in mental health services. This supports previous research that has found patients with personality disorder to have more convictions, and a history of detention in YOIs, prisons (Bailey and MacCulloch, 1992a, 1992b), and psychiatric admissions to mental health services (Coid et al, 1999:530).

This summary of the patient demographics highlights that there are very few differences between DSPD patients and prisoners in terms of their pre-institutional characteristics (see Table 3). Nearly all patients and prisoners had a history of disruptive childhood and adolescence. Nearly all had begun offending from an early age. The majority had a record of problematic alcohol and/or drug use. The majority had offended against people unknown to them. The main differences between the two samples were that DSPD patients were slightly younger than DSPD prisoners. Comparatively the offences committed by DSPD patients were less serious, as reflected by a higher number of them being given a determinate rather than life sentence.

	DSPD prisoners	DSPD patients
Pre-institutional characteristics	<ul style="list-style-type: none"> <li>• Average age 43</li> <li>• Disruptive childhood, some with experience of care system</li> <li>• High presence of previous drug and alcohol use</li> <li>• Most with extensive record of offending</li> <li>• Higher incidence of murder</li> <li>• Higher incidence of rape</li> <li>• Majority of victims unknown to offender.</li> </ul>	<ul style="list-style-type: none"> <li>• Average age 37</li> <li>• Disruptive childhood, some with experience of care system</li> <li>• Presence of previous drug and alcohol use</li> <li>• Most with extensive record of offending</li> <li>• Higher incidence of violent (but non-fatal) offending</li> <li>• Higher number of indecent assaults (rather than convictions for rape)</li> <li>• Majority of victims unknown to offender. More victims under 16.</li> </ul>

**Table 3: Pre-institutional characteristics of DSPD prisoners and patients**

### ***Getting into hospital***

In order to be detained in a hospital DSPD unit, individuals must satisfy the requirements of the MHA 1983<sup>60</sup>. For an individual to be detained under the MHA 1983, they must be assessed to have one of four mental disorders. Under mental health law, the closest legal category to personality disorder, is psychopathic disorder. In addition to the presence of psychopathic disorder, treatment in hospital must be

<sup>60</sup> The law described here relates to the MHA 1983 prior to the amendments under the MHA 2007 which came into force in November 2008 and made several significant changes to mental health law (see chapter 2 for further discussion, and for a detailed overview see Bowen (2008) and Jones (2008)).

considered 'likely to alleviate or prevent deterioration of his condition'<sup>61</sup>. Psychopathic disorder under the MHA 1983 is defined as:

a persistent disorder or disability of mind (whether or not including significant impairment of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the person concerned' (MHA, 1983, s1(2)).

Section 37 of the MHA 1983 allows the court to sentence a person who is considered to suffer from a mental disorder, and whose offence would ordinarily be punishable by imprisonment, to be made subject to a Hospital Order rather than a prison sentence. Alternatively, a 'Hospital and Limitations Directions' under section 45a of the Mental Health Act 1983 (as introduced by the Crime (Sentences) Act 1997) allows the courts to pass a prison sentence while also ordering their admission to hospital for treatment. Individuals under this section can be transferred back to prison at any time during their sentence to complete it. Sentenced prisoners can also be transferred to the mental health system while in prison under section 47 of the MHA 1983.

Section 41 and section 49 of the MHA 1983 allow a restriction order to be added to a section 37 order by the Crown Court, and to a section 47 order, by the Secretary of State, if it is felt that the public needs to be protected. A restriction order restricts the opportunities for release, in that it requires a recommendation from either a MHRT and/or the Secretary of State before discharge can be authorised. The number of restricted patients has steadily increased, and in 2006, 4,600 patients were subject to a restriction order, nearly twice as many as in 1993 (Srinivas et al, 2006, see also Ministry of Justice, 2007b). In practice, and in the case of s47 transfers, the Home Office usually exercises its power to add a restriction order under s49 (Mind, 2006)

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<sup>61</sup> This has been replaced with 'appropriate treatment is available' (s3(2)d) under the amended MHA 2007.

although this ceases when the patient reaches their Earliest Date of Release (EDR) as determined by the Non Parole Date (NPD) of their original prison sentence<sup>62</sup>. At this point, patients remain liable to detention under s41(5), commonly referred to as a 'notional section 37'. While a patient remains restricted under s49 they can be returned to prison at any point.

Between 1972 and 1995 twenty-eight percent of patients detained in the high security hospitals were detained under the legal category of psychopathic disorder (Reiss et al, 1999)<sup>63</sup>. This proportion has reduced according to the most recent statistics from the Ministry of Justice (2007) that report that thirteen percent of restricted patients in the mental health system are currently detained under the legal category of psychopathic disorder<sup>64</sup>. Of the restricted patients currently detained under the legal category of psychopathic disorder in the mental health system, seventy percent are detained under a s37/41, twenty-seven percent under a s47, and three percent under s45a.

Previous research has identified that some patients are resentful of a s37/41 disposal and would have preferred a prison sentence rather than to have been coerced into treatment (Dell and Robertson, 1988). However, while the majority of patients with personality disorder still come from Court<sup>65</sup>, previous research has identified that between 1960 and 1983 admissions from court to one high security hospital declined, while the proportion of transfers of prisoners at a late stage of their determinate

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<sup>62</sup> The NPD is the point at which prisoners have completed two thirds of their sentence,

<sup>63</sup> See also Dell and Robertson (1988) who found that twenty-five percent of male patients from Broadmoor were detained under psychopathic disorder and Hamilton (1990) who identified that twenty-four percent of patients in the high security hospitals were detained under psychopathic disorder.

<sup>64</sup> It is unfortunate that these statistics only record details of restricted patients, as it is likely that many patients, particularly those with personality disorder and more likely to be transferred from prison towards the end of their sentence, are detained under a section 41(5), i.e. their prison sentence has expired and they are no longer restricted under mental health legislation.

<sup>65</sup> Previous research has found that eighty-seven percent of patients classified with psychopathic disorder in one hospital had come from court (Dell and Robertson, 1988), while Woods and Mason (1996:14) reported that just over sixty-nine percent of admissions were from court.

sentence increased (Grounds, 1991). This trend has continued and since that time the proportion of admissions from Court of people with personality disorder declined between 1988 and 1994 (Coid et al, 1999:529) and between 1986 and 1995, with a corresponding increase in the number of admissions from the Prison Service (Jamieson et al, 2000). This supports research that suggests that the selection for Hospital Orders under the legal category of psychopathic disorder may be arbitrary (Davis, 1994; Maden, 1999; Collins, 1991). Although the reports to the MHRT did not give details of the deliberations that took place at the time of sentencing it is of note that only three of the sample were originally serving a Hospital Order.

### ***The traditional hospital journey***

The forensic mental health system in England and Wales is broadly structured along the lines of high, medium and low security facilities, although there are no agreed definitions of the different levels of security in medium and low security services (Collins and Davies, 2005; Department of Health, 2000c; Maden, 2008). Often, these facilities do not meet need with services (Department of Health, 2000c) and in practice, much variation exists in how these different levels of security operate. High security mental health services are provided by three secure hospitals (previously known as the Special Hospitals), namely: Broadmoor, Rampton and Ashworth. These hospitals provide secure treatment for individuals on the basis of them being deemed to be 'dangerous, violent or having criminal propensities' (NHS Act 1977), and following the Tilt et al (2000) report are expected to be as secure as Category B prisons. It is estimated that there are about nine hundred beds across the three high security hospitals and approximately four thousand beds available in medium secure units (Maden, 2008:138-9).

Once in hospitals, patients are looked after by multidisciplinary teams that are most often comprised of psychiatrists, psychologists, nurses, social workers, and



occupational therapists. Patients, like prisoners, can also expect regular reviews of their case under the Care Programme Approach (CPA), introduced in 1991 (see Kingdon, 1994; DoH, 1995). The CPA should provide a framework within forensic settings ‘that facilitates an assessment and treatment approach that combines an understanding of both a patient’s mental health and their potential risks’ (Gournay et al, 2008:531). At the heart of this process are four main elements: assessment of health and social needs; development of a care plan that should identify relevant providers; appointment of a care coordinator; and regular case conferences to review the care plan<sup>66</sup>.

Importantly, and in contrast to the Prison Service, Gournay et al (2008:530) observes that it ‘would be a mistake to assume that patients in England seamlessly travel down levels of security until final discharge to community care’. Furthermore, patients with personality disorder are more likely to be discharged directly to the community than those with mental illness (Special Hospital Services Authority, 1995; Reiss et al, 1999). A study of the discharge routes for patients with personality disorder revealed that patients discharged straight from high security into the community were likely to have had more court appearances, served more custodial sentences, and spent less time in high security before discharge, when compared to a group of patients discharged to medium security facilities (Davison et al, 1999:224-5). This suggests that patients with personality disorder are often excluded from medium secure services (Grounds et al, 2004).

### ***The journeys of DSPD patients***

Of the sample of twenty-four patients with a MHRT since DSPD admission, eighteen had been transferred into DSPD directly from the Prison Service, while six had been transferred into the hospital-based DSPD services from elsewhere in the mental health

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<sup>66</sup> See McMurran et al (2009) for more information.

system. Of the eighteen patients who had been transferred into DSPD from prison, seven were transferred from HMP Whitemoor or Frankland either from the prison-based DSPD services or following previous assessment (1006, 1013, 1015, 1019, 3004, 3010, 3020), three from elsewhere in the high security prison estate (1008, 1018, 3030), four from Category B prisons (1005, 1010, 1020, 3015), three from Category C prisons (1016, 3002, 3024), and one from a private prison with no reception criteria (3023). In comparison to the prisoner sample, most of whom had been transferred from a high security prison, participants in the hospital-based services were transferred from different security levels of the prison estate. Of the six patients transferred from elsewhere in the mental health system, four (3003, 3016, 3017, 3028) had been transferred from a high security hospital, and two from medium secure services (1001, 1022).

	DSPD prisoners	DSPD patients
Legal status	<ul style="list-style-type: none"> <li>• 94% life sentence prisoners, 6% determinate prisoners</li> <li>• Average tariff of 8 years (lifer), Average sentence of 5.25 years (determinate)</li> </ul>	<ul style="list-style-type: none"> <li>• 12% restricted hospital order, 67% determinate prison transfer, 21% life prison transfer</li> <li>• Average tariff of 8.2 years (lifer), Average sentence of 7.5 years (determinate)</li> </ul>

**Table 4: Legal status of DSPD prisoners and patients at time of admission to DSPD services**

A number of different and sometimes complex legal statuses were found amongst the patient sample, with the original legal status of DSPD patients differing considerably from the DSPD prisoners (see Table 4). At the time of admission to DSPD, three of the twenty-four patients (1001, 3016, 3024) with a MHRT following DSPD admission, had originally been given a restricted hospital order (s37/41) by the Court and were

transferred to the mental health system (although in the first instance, not DSPD services). Importantly only one of these participants (1001) had not spent time in the Prison Service since sentencing for the index offence and his restriction order had expired by his time of admission to DSPD. The other two patients originally detained under s37/41 were convicted of other offences while in the mental health system, sent to prison, and then recalled to hospital from their previous s37/41 section. This may highlight the emerging zero tolerance to violence in the NHS, and the increasing responsabilisation of individuals with personality disorder.

The remaining twenty-one patients had been transferred to a hospital DSPD unit from the Prison Service on either a s47 or s47/49 of the MHA1983, although a few had been transferred elsewhere in the mental health system and then referred and admitted to DSPD. This high proportion of prison transfers (eighty-eight percent of the DSPD patient sample) echoes the findings of Grounds (1991) and Jamieson et al (2000) that admissions of people with personality disorder from Court have been in decline, while the proportion of sentenced prisoners transferred to hospital has increased. No patient in the sample was detained under a s45a reflecting that little use of this section is made<sup>67</sup>.

The sentences that these participants had been serving in the Prison Service varied enormously. Of the twenty-one participants with an original criminal justice disposal, sixteen had been serving a determinate sentence with a sentence length of between fifteen months and six years, while five were serving a life sentence, with a tariff of between six and ten years. The time patients had served since conviction ranged from just under two years to just over twenty-one years. On average patients had spent just over nine years in prison or hospital since conviction for their index offence.

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<sup>67</sup> This could be argued to be fortunate given Cavadino's (1998) concerns that this legal provision places individuals with personality disorder in a 'triple no-win situation'. See also Eastman and Peay (1998).

The high presence of determinate sentence prisoners in the DSPD hospital units, suggests that admission is as much to do with sentence length and public protection, as it is with treatment. This highlights that groups are often delineated for socio-political reasons rather than for medical and psychological ones (Greig, 1997) and that many referrals to high security hospitals are for preventative rather than rehabilitative purposes (Wahidin and Powell, 2001). 'In practice then it is the crime, which is regarded as proof of a disorder' when decisions are made about admission to secure hospitals (Wahidin and Powell, 2001:32). This presents somewhat of a double standard in that a high number of individuals are turned away from the mental health system at the time of sentencing yet admitted for treatment once their prison sentence has expired. It also points to a number of paradoxes that are raised by compulsory treatment in the mental health system, including that:

we impose treatment on those who reject it sometimes in priority over those who seek treatment but cannot obtain it [and] that we concern ourselves increasingly with questions of risk and less with issues of health (Peay, 2003:ix).

It was unfortunate, especially given the large number of prison transfers, that relatively little information regarding sentencing and information about a patient's institutional behaviour in prison prior to hospital admission, was available in the reports submitted to the MHRT. Far more information however is available about their institutional behaviour and response to DSPD, which is discussed in the next chapter. In some respects, this focus of report writers in the mental health system, suggests that once a prisoner is transferred into the mental health system, report writers are keen to present him as a patient, and as a result his previous identity as a prisoner is given less attention. It may also be the case that information does not travel that well between the prison service and the mental health system.

It was difficult to establish the previous prison security category of patients, but when the information was available patients were most often categorised as either category B or C. The absence of this information illustrates that the high security hospitals are not routinely notified of security categorisation and that this information is not held centrally (Tilt et al, 2000). Records of adjudications, segregation, transfers, attitude to their offence, completion of treatment programmes, and previous experience of PB reviews were also difficult to establish<sup>68</sup>. This was a cause for concern amongst some of the staff in the hospital sites who commented on the unavailability of information about what had previously gone on in prison prior to the patient's transfer and admission to hospital.

### ***Dangerous and disruptive journeys***

It appeared that several of the patients who had previously spent time in the prison system had experienced several transfers within the prison estate (1016, 3016, 3020). Several had a record of being held on segregation units (1016, 1020, 3024) with one participant (1020) transferred directly to DSPD from segregation.

Some patients also had a record of adjudications during their prison sentence, with several having assaulted staff and fellow prisoners (1013, 3016, 3020, 3024), possessed or used weapons (1013, 1020 3004, 3016, 3020, 3023, 3024), been involved with bullying or intimidating behaviour (1013, 1016, 3016, 3023) and to have threatened (1016) or actually taken other prisoners hostage (3024). A few were also suspected as having taken drugs and/or been involved with their supply during their imprisonment (1008, 1015).

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<sup>68</sup> It is important to note that some of this information may be available to staff in MH services by other means, but it is not included in reports to MHRT

A few patients convicted of sexual offences were noted to have formed relationships with other sex offenders, and recorded as a risk to younger and more vulnerable prisoners because of their sexually motivated and predatory behavior towards other prisoners (1013, 1018, 3017, 3028). The reports for one patient identified that:

At HMP Wakefield 1018 was described as bullying another prisoner for sexual favours, that a prisoner had complained of 1018 watching him in the shower and that 1018 had been masturbating in the communal areas in prison and on another occasion when 1018 exposed himself to another prisoner (1018, Social circumstances report).

Other patients had a record of behaving inappropriately to female staff in the Prison Service (1015, 1016, 1019, 3015). The reports for one patient identified that:

reports from the SOTP and other records record 1008s expressions of a general and enduring level of hostility towards women. I therefore consider that 1008 poses a high risk to women particularly those by whom he experiences actual or perceived rejection (1008, Social circumstances report).

Five patients (1013, 1016, 3002, 3023, 3024) who were previously serving determinate sentences were released from prison but then recalled to serve the rest of their sentence in prison. The reports for one patient noted that:

Less than 24 hrs following his release ... 1013 was recalled ... for breaching the terms of his license. On the day of his release he was noted to have approached two separate males ages 11 and 12, while being watched by a Met Police surveillance operation and when he tried to get the second child to follow him he was arrested (1013, Social circumstances report).

### ***Vulnerable and hidden journeys***

Several patients were recorded as having a stressful and disturbing experience (1019, 3024) while in the Prison Service, and a history of serious self harm and suicidal ideation (1005, 1013, 3010, 3003, 3020, 3024, 3028). Several patients were recorded as having been isolated during their time in prison (1005, 1019), having not got on with their peers (1005), or as having many enemies (1020). Occasionally reports highlighted that patients had been previously assaulted by fellow prisoners (3023) or had been detained on VPUs (3015).

### ***Stable journeys***

Those for whom information was available, like the prisoners, were found to have mixed experiences of the prison system. The behaviour of a few was described as relatively settled, with an absence of an adjudications and segregation record (1005, 1019, 3010). However, and similarly to the prisoner sample, there was concern about the genuineness of their behaviour, anxiety about the absence of offending behaviour work, and scepticism about the real progress made.

### ***Treatment journeys***

Most were recorded as having completed and/or engaged with little offending behaviour work (1005, 1010, 1013, 1015, 1016, 3004, 3015). This was attributed either to courses (particularly the SOTP) not being made available to them, either because of resources, a high PCL-R score (1005, 1013, 1015), or because they lacked the ability to properly engage (1005, 1010, 1019, 3015). On occasions the reports recognised that completion of offending behaviour work was largely beyond their control (1005). Where patients had completed offending behaviour work, doubt is cast about the long term benefits of the intervention (1010, 1015, 1019). Several were reported to have difficulties trusting professional staff and other prisoners or patients in group-based treatment.

A few participants were identified as having previously been placed in Grendon (1013, 1015, 3004, 3024) or Dovegate (1020). Clearly by their referral and admission to DSPD services these were unsuccessful placements, with patients recorded as having failed to complete treatment because they 'lack the intellect to engage or benefit in therapy' (1013) or because they refused to attend treatment sessions on the basis that they wanted to do therapy 'in their own way' (1015). Another patient alleged that he was raped at Grendon, so was transferred out, and that he was not given adequate support by staff (3024)

### ***Hospital journeys***

Although information about the prison journeys of DSPD patients was often brief and/or absent from the reports, where DSPD patients had spent time in the mental health system prior to DSPD admission (1001, 1022, 3003, 3016, 3017, 3028), far more information about their institutional behaviour and experiences in hospital prior to DSPD admission was available.

Analysis of the reports identified that only one participant, (1001) had not spent time in prison since sentencing for his index offence. In the early part of his hospital career he was described as 'exploitative, selfish, complaining, manipulative and aggressive'. While he was later described as having settled, to the point where on two occasions a discharge plan was put in place, these were suspended following a deterioration in behaviour. His failure to convince professionals that he could cope with conditions of lesser security, and the fact that it was no longer appropriate for him to stay on an adolescent unit, led to him moving back up the security hierarchy, and into DSPD services.

This record of progression to conditions of lower security, and then failure to respond to less restrictive conditions, appeared to be a common story amongst some of the



patient sample. Another patient, (3028) was originally sentenced to a thirty month term of imprisonment following his conviction for grievous bodily harm (GBH), arson, actual bodily harm (ABH), assaulting a police officer and possession of an offensive weapon. Prior to sentencing he was recommended for an Interim Hospital Order under section 38 of the MHA, but because a bed could not be found for him, the Judge decided, rather than delay matters, to sentence him to a term of imprisonment. Later, 3028 was transferred to the mental health system. At one point he is recorded as having been able to make progress to one of the villas (a lower security facility) within a high security hospital. He is then recorded as having deteriorated, threatened self harm, and having been returned to the main hospital wards. After this point he experienced several transfers around the hospital where he continued to display a range of inappropriate behaviours. Following an incident where 3028 tried to strangle a patient and a nursing assistant he was prosecuted and received another term of imprisonment. Towards the end of this term of imprisonment he was returned to hospital. Although his behaviour was still recorded as inappropriate, some improvements were noted. His behaviour is documented as continuing to improve until, following the funeral of a grandparent, he was identified as having become very withdrawn, attempting to subvert security, and as behaving in a predatory way towards other male patients. It is at this stage that DSPD was identified as an opportunity to allow 3028 a 'fresh start'.

3016 and 3024, both original s37/41 patients, displayed similar patterns in that their behaviour in hospital was particularly disruptive, eventually culminating in further prosecution for serious offences including an assault on staff, threats to kill (3016), ABH, and attempted escape (3024). This led to these participants spending time in the Prison Service, where their behaviour continued to be disruptive to both staff and other prisoners. This demonstrates that a small number of DSPD patients have been resentenced while in the mental health system. Once these prisoners were coming to

the end of their sentence, anxieties clearly surrounded their release, and both were recalled to hospital under their original s37/41 order.

Most of the patients who had spent time in the hospital system prior to DSPD were, like many of the patients who had transferred from prison straight into DSPD, coming towards the end of their determinate sentence when they were transferred to hospital. Towards the end of his sentence 3003 was transferred to a prison DSPD unit, where he was found to meet DSPD criteria, but because of the length of his sentence left to serve, was referred to a hospital DSPD unit. At the time of his referral, the patient's catchment DSPD hospital unit was closed to admissions so he was first admitted to the other hospital DSPD unit, and then later transferred to his catchment DSPD hospital unit. During this time it appears that he was unable to partake in any therapy. Similarly, the case of 1022 who was transferred to a medium secure unit towards the end of his prison sentence following his admission that he was still getting feelings for young boys, later complained that he spent two and a half years waiting to get onto the DSPD unit.

### **Exploring the lack of career progress and the journey into DSPD**

A diversity of pre-DSPD admission responses amongst the patients and prisoners can be discerned from the reports submitted to the PB and MHRT. The majority of patients and prisoners were identified as having been disruptive while in the Prison Service, leading to a number of adjudications and time in and out of segregation, healthcare or VPUs. One prisoner who had experienced several transfers between high security hospitals and prisons, during which he was in and out of healthcare and segregation, was described as having:

never come to terms with his sentence, and his negative anti authority attitude and failure to cope with the normal prison environment meant that little could be

done for him ... he was a highly manipulative individual whose demands were masked in thinly veiled threats ... he minimised his offences, and it was impossible to do any positive work with him or his offending behaviour. At that stage there was no prospect of rehabilitation in or out of custody ... records highlighted numerous examples where antisocial, unacceptable behaviour have terminated attempts at rehabilitative therapy, both in prisons and special hospitals. 2046 could not see that his past and current behaviour was almost totally impeding him (2046, 6(3) Summary of progress in prison).

The records of another prisoner who, despite being considered to have made some improvements in his coping strategies in DSPD, had a previous record of adjudications and segregation, was considered to have:

formed a pattern where he feels the need to run away from problems and not face them. This brings in the need to be moved around establishments which means no work being completed on his offending behaviour (2035, 3(1) Personal officer).

The records for another prisoner convicted of arson and frustrated by his lack of progress through the prison system, was recorded as blaming this on the system rather than his own actions:

He was caught up in his own frustrations and embitterment. He was still impulsive and had spent 16 years shuttling between B and C category status, distanced from his home area and with a lack of progress, whilst seeing other prisoners, often with violent and sexual convictions getting released or making progress (2048, 10(1) Summary of progress in prison).

These comments suggest that disruptive and unco-operative prisoners have rarely been able to complete offending behaviour treatment successfully. Those who had been managed in segregation and healthcare units, often for their own protection, had rarely made any substantial progress. This demonstrates that one of the particular difficulties for prisoners in segregation, or those subject to numerous transfers is that their opportunities to complete offending behaviour treatment and meet the requirements of their sentence plan are limited. The consequence of this is that many DSPD patients and prisoners are presented as more difficult to know. Location in a healthcare setting may also lead report writers and external decision-makers to feel more uncertain about the extent to which a prisoner is unable or unwilling to address his offending behaviour. The records for a generally co-operative, but vulnerable prisoner noted that:

he had spent the majority of time in the segregation unit. He has not coped well during his sentence, his mental health has been an ongoing issue and this makes it difficult to assess whether his lack of progress is due to him being *unwilling, unmotivated or unable* to participate in the sentence planning process (2047, 4(1) Seconded probation officer).

While it was not always wholly clear from the PB and MHRT reports what had led a DSPD patient or prisoner to be referred and then admitted to DSPD services, some common reasons were apparent. The primary reasons behind a referral to the prison-based DSPD services appeared to follow assessments that they were unlikely to benefit from traditional offending behaviour programmes, recognition that they had completed very little offending behaviour work, or because of anxieties that the work they had completed had had a limited effect. Several prisoners had also failed in specialist settings including Grendon and CRC units, and in this respect, DSPD is

framed as the last and only opportunity left for treatment, and for the authorities to manage risk.

Several of the patients transferred to the hospital DSPD sites had previously been assessed and/or admitted to the DSPD services in prison (1006, 1013, 1015, 1019, 3003, 3004, 3010, 3020), and in the main it appeared that their transfer to hospital was a result of there being insufficient time for them to complete DSPD treatment in prison. It is also of note that several patients, prior to their transfer to the mental health system, had been released on license, recalled to prison, and then sectioned under mental health legislation. It could be argued that the hospital DSPD services have sometimes operated as a form of preventive detention. Other reasons behind transfers to the mental health system followed concerns that little offending behaviour work had been completed, that patients were struggling to engage in offending behaviour work, or because they were reported as having become increasingly paranoid in prison.

## **Conclusions**

Following unique access to a sample of both DSPD prisoners and patients, this chapter has described the characteristics of both groups and considered their journeys prior to their admission to DSPD services. It was evident that DSPD patients and prisoners have adopted a range of strategies to manage their detention prior to placement in DSPD services. Before DSPD admission, patients and prisoners were most often presented as resistant, with very few identified as co-operative. It was unfortunate that less information about the previous prison careers of the patient sample was available, but this might indicate that once an individual is admitted to mental health services, they become a patient, and as a consequence, their identity as a prisoner is seen as less relevant.

The analysis suggests that in many respects these are participants whom we haven't wanted or been able to know. From an early stage many of the participants have experienced several unsettling moves in their childhood and adolescence, between parents and the care system. Problematically, the majority report abuse of an emotional, physical and sexual nature by both male and female parents, carers and strangers, highlighting that they are a 'client group who have often lived through deeply traumatic experiences in childhood and young adulthood' (Moore and Freestone, 2006:193). While their records of offending are serious, so too is the abuse that the majority have suffered, suggesting that while 'they have certainly injured their fellows ... perhaps society has unwittingly injured them' (Glover, 1956:267, quoted in Pratt, 2007:388).

Many had a serious record of truancy, running away from home and exclusion from school. Frequent reference was made by the reports to approved schools, low educational attainment, and for many, history of admissions to YOIs, prisons, and psychiatric facilities. Many had records of serious offending from adolescence, often escalating in seriousness. At the time of sentencing, many of the PB dossiers alluded to the difficulties in deciding about the appropriate disposal and treatment of personality disorder. It is of note that all but three of the total sample were originally sentenced to a term of imprisonment, and of those three who were given an original hospital order, only one of these, was not subsequently transferred to the Prison Service.

Once in the Prison Service, many were managed away from 'normal location' and excluded from traditional Prison Service treatment programmes, because assessment identified them to have a high PCL-R score. Others, particularly those coming towards the end of a determinate sentence, have found themselves transferred to the mental health system at the last minute.

The institutional behaviour of many of the DSPD participants was framed as particularly problematic. A number of different reasons were identified for adjudications including threats and assaults to both staff and prisoners. Records of segregation and transfers were commonplace for many prisoners. A few prisoners had been transferred to specialist units including CRC units and HMP Grendon.

While many of those in the DSPD units had displayed disruptive and maladaptive behaviour during their prison careers, many were also described as withdrawn and isolated. Often those who had bullied others then found themselves in protective custody because of fears of repercussions. This highlights research by Coid et al (2003:315) that 'suggests that victimisers may be more likely to be victims in prison', and is significant in terms of Morris' (2004b:29) observation that 'paradoxically while the psychopaths are perceived as the "hard men" of popular culture ... the opposite may be true'.

While some prisoners and patients were considered to have relatively stable careers in prison, the majority are still considered to have made little progress. Those who have completed offending behaviour work are treated with some scepticism. Many with a record of good behaviour were also found to have a record of dangerous attitudes, and this display of disordered thinking (rather than overt display of aggression/disordered behaviour) is presented as just as challenging and dangerous. A record of good behaviour is not enough in the case of DSPD participants, and in fact, can often be used to evidence beliefs that those with personality disorder are highly capable of manipulating the situation to their own advantage.

The findings and discussion of this chapter highlight that this group have often been largely ignored or passed between a number of services. This is important because difficulty in accessing services or being passed between clinicians is likely to damage

the confidence and trust of patients (Antebi, 2003). It would appear that services and professionals at all stage of their lives either haven't wanted to know, or haven't known what to do with them. When attempts have been made to know them, professionals have either struggled to know, or treated the motivation of patients and prisoners to be known as flawed. Importantly though, the individual patients and prisoners themselves must also take responsibility for their institutional journeys prior to DSPD, as many have also presented as not wanting to know, or be known. Many have spent a considerable part of their sentence either being disruptive or doing nothing to reduce their risk. When opportunities have presented, their behaviour or lack of engagement has meant that they have not been able to make full use of them. It is for this reason that many DSPD referrals appear to have been initiated, and for those who have not done anything constructive during a determinate sentence, or who have breached their license within a short period of being released, they have found themselves transferred to the mental health system for treatment and detention long beyond expiry of their original sentence.



## **6. The journeys of prisoners and patients following DSPD admission**

*Can we know the risks we face, now or in the future? No, we cannot: but yes, we must  
act as if we do (Douglas and Wildavsky, 1983:1)*

*We build a history on this faulty thing [what the prisoner says]. We really need to know  
who they are (Mental health worker, quoted in Rhodes, 2004:126)*

### **Introduction**

The previous chapter described the characteristics of the sample and their institutional journeys prior to DSPD admission. Patients and prisoners were identified as possessing many similar characteristics and institutional responses, with most having been disruptive during their prison career. Many, including those who were identified as disruptive, were also presented as a vulnerable and largely unknown population. The majority were recorded as having completed an unsatisfactory amount of offending behaviour work. This chapter continues the journey of patients and prisoners following their admission to DSPD, by considering how the reports submitted to the PB and MHRT describe the patients and prisoners, the DSPD units, and the future.

### **Getting into the DSPD units**

An individual can be admitted to a hospital or prison based DSPD unit if assessment demonstrates that:

- 1) He is more likely than not to commit an offence that might be expected to lead to serious physical or psychological harm from which the victim would find it difficult or impossible to recover, and,
- 2) He has a severe disorder of personality, and,
- 3) There is a link between the disorder and the risk of offending (DSPD Programme, 2005a:8).

As identified in chapter two, although the admission criteria for the four high security units are the same, patients admitted to the hospital units must also meet the criteria of the Mental Health Act 1983. This means that the patient must be considered to have a 'psychopathic disorder' of a 'nature or degree' which makes it appropriate for the patient to receive medical treatment in hospital. In addition, medical treatment must be considered as likely to 'alleviate or prevent a deterioration' in the patient's condition.

Referrals can be initiated by anyone in regular contact with someone they believe meets the criteria. Referrals to the prison-based sites should be made in accordance with the prisoner's probation catchment area while referrals to the hospital-based units should be made according to the patient (or prisoner's) strategic health authority catchment area (see DSPD Programme, 2008b for a list of catchment areas). The DSPD guidance expects most referrals to come from prisons within the Directorate of High Security (DHS), although advises that referrals from lower security prisons may also be considered, as well as, in exceptional circumstances, from the community via MAPPA and local forensic mental health services. Other sources for admission to DSPD include those already in hospital, and from the courts under the MHA 1983.

The DSPD guidance suggests a number of criteria for prioritising admission, including the existing population mix of the unit, the amount of time individuals have spent on waiting lists, and importantly, that:

[p]riority for allocation of places should be given in the first instance, to those prisoners who present the most serious and immediate threat to public protection, most likely to be high-risk prisoners serving determinate sentences. Where a life-sentenced prisoner is referred to a unit, public protection considerations (tariff and length of time to possible release) should be a major factor in determining the prisoner's priority for admission (DSPD Programme, 2005a:12).

This highlights that the DSPD programme is keen to ensure that 'treatment services are structured and focused around facilitating progression through reducing risk' (DSPD Programme, 2005a:8), and that public protection is a key objective. It may sometimes be more appropriate to refer individuals to the hospital based units if:

- the individual has mental health treatment needs that can be best met in a hospital environment
- an individual is near the end of their sentence and is likely to require continued detention under mental health legislation in order to complete treatment (DSPD Programme, 2005a:10).

As a general rule, the guidance suggests that those with less than a year of their sentence to serve should be referred directly to one of the hospital units, and those with over twelve months should initially be referred to one of the prison based pilot

units. This suggests that sentence type and length are directly related to decisions about DSPD admission.

The DSPD guidance advises that both 'static and dynamic tools will be used to help inform a structured clinical judgement' to establish if the criteria are met (DSPD Programme, 2005a:14). To this end, a number of risk assessment tools are suggested: the Violence-Risk Scale (VRS) and Historic-Clinical-Risk Scale (HCR-20) to assess the risk of violence; the Risk Matrix 2000, Static 99 and the Structured Assessment of Risk and Need (SARN) to assess the risk of sexual offending; the Psychopathy Checklist-Revised (PCL-R), Psychopathy Checklist-Shortened Version (PCL-SV) and the International Personality Disorder Examination (IPDE) to assess the presence of personality disorder and finally, the Structured Clinical Interview for the DSM-IV-TR (SCID-1) to assess the presence of mental illness (DSPD Programme, 2005a).

## **Getting on in the DSPD prison units**

### ***Getting to know the DSPD prisoners***

With the exception of two prisoners serving a two and a half (2025) and an eight (2044) year determinate sentence, the DSPD prisoners were all serving a life sentence with an average tariff of eight and a half years. At the time of admission to DSPD, prisoners had served an average of eleven years of their sentence, and by the end of the study period had been in prison between five years, two months and twenty-seven and a half years<sup>69</sup>. On average prisoners had spent about three and a half years on a DSPD unit, ranging from just under two years, to just over six and a half years.

Following admission to DSPD a very small number of participants had been transferred to the mental health system and then returned. One prisoner, serving a determinate

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<sup>69</sup> These figures demonstrate that the sample described here are those eligible for review, and hence most likely to be over tariff.

sentence, was resented on a number of occasions for crimes committed in prison, finally receiving an IPP sentence while resident in DSPD. This highlights that it was rare for prisoners to experience a change in legal status post DSPD admission.

The reports supplied to the PB revealed, in stark contrast to previous reports, that nearly all the prisoners had behaved well since DSPD admission, most often evidenced by a reduction in adjudications and the use of segregation:

2040's main progress so far has been the change in his behaviour as compared with previous behaviour in the community and in custody ... evident in a significant reduction in aggressive behaviour (2040, 4(2) Psychiatrist report).

Improvements in staff and peer relationships were also given as an indication of progress in DSPD:

2044's behaviour has changed significantly since coming to the unit; he initially presented as hostile, judgmental and aggressive. Nowadays 2044 benefits from good relationships with staff and other inmates and he is a personable character on the wing (2044, 1(1) Seconded probation officer report).

For many prisoners, improvements were also evidenced by an increasing motivation to engage with treatment. The reports for one prisoner, noted:

from my knowledge of 2056 I think there may have been some reduction in risk related to general improvement of behaviour, more recently through engagement with treatment on the [DSPD] unit (2056, 4(3) Psychiatrist report).

Those who had struggled to adapt to DSPD units, were still commended for their renewed outlook and motivation towards change. For one prisoner, the psychiatrist comments:

there is also agreement that despite his repeatedly stated reluctance 2032 has made very clear progress in engaging with psychological treatment (2032, 3(1) Psychiatrist report).

This suggests that the PB review may be used as an opportunity to encourage and commend participation, and in some cases, to re-iterate that treatment is having a positive effect, even if the prisoner does not agree. Even those who were 'unable to fully participate' were identified as making progress:

He has been unable to fully participate in the treatment programme and there is no indication at present that he is likely to be able to do so in the short/medium term. Despite his limited participation in treatment, his overall improved interaction with staff ... is considered to be an indication of reduced risk in this setting (2046, 6(3), Psychiatrist report).

Another prisoner was:

commended for his limited participation as he had been living in segregation units for two years before coming to [DSPD] (2047, 4(1) Seconded probation officer report).

There are inherent problems with trying to assess why the behaviour of prisoners may have improved following DSPD admission. Although research has shown a reduction of violence in the DSPD unit at HMP Whitemoor, this may simply have been due to

maturation (Taylor, 2003; see also Cooke, 1989), or because violence and aggression are defined and interpreted differently in the DSPD units. This may be a consequence of staff assumptions that the units have been set up to cater for a certain type of individual (Goffman, 1961), and because they have a vested interest in a positive presentation to outsiders, and a need to inspire confidence in the DSPD participants and outsiders about the potential benefits of the programme. It was apparent from a few reports, that behaviour previously interpreted as difficult may be redefined in the context of a DSPD placement:

He can at times be demanding and unreceptive but this is in my view a reflection of human nature, rather than him being deliberately anti social (2044, 1(1) Seconded probation officer report).

Several reasons were identified for improvements in behaviour, but were most often attributed to the physical, relational and procedural security of the DSPD units. This highlights that surveillance in prisons often reduces opportunities to engage in criminality (Blumstein, 1995; Hepburn, 1985; King, 1999). In one case, the Lifer Manager noted that:

4023 put this improvement in behaviour down to the high staffing levels and CCTV system in operation on [the DSPD] unit as he states he could not get away with assaulting prisoners like he could at previous establishments (4023, 6(1) Lifer manager report).

For another prisoner:

the main progress has been that he has not acted out violent thoughts in the last few years but he has been in relatively protected and/or high staffed environments throughout this time (2047, 4(1) Psychiatrist report).

Other reports gave credit to the treatment programme, and the prisoners input into the therapy. In one review, it was identified:

his adjudications have all been for bad behaviour and damaging prison property. This was a pattern in the early part of his sentence, however he has had none since ... 2 years ago. This is a direct result of his therapy on the [DSPD unit]. His behaviour on arrival was I am told very bad, and as a result of how he was treated, and his own input into his therapy, this improved to a high standard (2044, 1(1) Personal officer report).

Improvements in behaviour were also attributed to a belief amongst some prisoners that treatment in DSPD represents their last realistic opportunity to progress towards release:

behaviour would have appeared to have improved considerably since his reception onto the [DSPD] unit ... this improvement would appear to result from a recognition on 4020's part that this is his last real opportunity to effect the necessary change to both secure release and remain in the community long term (4020, 1(1) Seconded probation officer report).

after transfer to the DSPD unit ... he was co-operative, (although still wary) seeing this as probably his last chance for treatment (2052, 2(2) Psychiatrist report).



While DSPD was identified as having led to positive changes in the behaviour and engagement of individual prisoners, all were still presented as particularly high risk. Although the reports devoted much attention to outlining all the risk factors identified by DSPD assessment, descriptions regarding their progress in treatment and reduction in risk were less clear. This highlights the short time that some participants had spent on DSPD, and that many were still in the assessment phase at the time of their PB review. However, even for those who had spent longer periods of time on the unit, discussion of the extent of risk reduction is still largely absent from the reports. This indicates that progress in treatment did not necessarily equate to a reduction in risk:

it is not disputed that 2044 has made significant progress in his treatment on the DSPDU but this does not mean that he has demonstrated a significant reduction in risk (2044, 1(1) Seconded probation officer report).

In another dossier:

report writers acknowledged the positive steps 2057 was taking to explore his offending history and that he was benefitting from the pilot programme being run in the DSPD unit. However, all those who made a recommendation on risk, stated that he remained at high risk of reoffending and should continue with the work (2057, 3(3) Summary of progress in prison).

Assessments of risk reduction were presented as unknown until the prisoners had successfully completed the DSPD intervention. In one review it was noted that:

he states he has not been able to do much else in terms of reducing risk or addressing offending behaviour during custody as he states he has not been allowed to access SOTP and other associated courses. With this in mind I feel

that there has been no reduction in risk and that this can only be fully assessed upon completion of the [DSPD] intervention programme (2039, 3(1) Personal officer report).

This suggests that high risk was evidenced by a lack of previous completion of offending behaviour programmes. In addition, the high security location, security categorisation, and previous behaviour of the prisoner, were used to evidence high risk and justify why a transfer to conditions of lower security would be inappropriate. In one case, the psychiatrist observed:

he is currently located in a high security prison and it would be inappropriate to consider his moving on from the unit when he is only just commencing treatment (2030, 3(1) Psychiatrist report).

This illustrates that transfers around the prison estate are not encouraged until prisoners have completed their treatment programme. These statements also indicate that the units use the review to send messages to both the prisoner and the PB about where prisoners are in their prison career, and that DSPD is an appropriate placement. For another prisoner, it was identified that:

still a category A prisoner in dispersal conditions ... spent most of his sentence in segregation, and a variety of special units, hospital ... therefore it is not appropriate to consider suitability for open conditions or release (2035, 3(1) Psychiatrist report).

The confirmation of high risk but ambivalence about the reduction of risk, indicates that many DSPD participants are presented as something of an unknown quantity, and that

much caution exists in the management and treatment of DSPD prisoners. For one prisoner, the seconded probation officer noted:

2057 is still something of an unknown quantity and it is possible that his dangerousness and risk to the public has been overestimated. However I would be concerned about how he may react if he believed he was not being seen as a dangerous person and placed in a less secure environment (2057, 3(3) Seconded probation officer report).

DSPD prisoners were also depicted as a vulnerable and guarded population, with varying degrees of trust in treatment:

When asked if he had any problems ... 'of course I've got problems, it's stupid to say no it would be like denying they're being there' ... when he was asked to expand on what he meant ... 'I don't want specifics on there (in the report) for other people to read' (4005, 2(1) Psychologist report).

Another prisoner was reported as having:

declined the opportunity to have input towards this report and states 'why should [staff] write reports on him when they do not know him'. He has declined probation LSP3B interview (4006, 2(1) Wing manager report).

The high level of emotional, physical and sexual abuse amongst DSPD participants is presented as making their treatment particularly challenging. The seconded probation officer for one prisoner who had been described as having a particularly unstable upbringing, notes that:

2047 does exhibit all the traits of a person who has been subject to sexual abuse; these include angry outbursts, distrust and withdrawal (2047, 4(1) Seconded probation officer report).

The psychologist for another prisoner notes:

2056 is very fearful of exposing his vulnerability and struggles to work through the stages of his childhood traumas thus relying on maladaptive coping behaviours (2056, 4(3) Psychologist report).

Those prisoners who had begun to open up to the unit and develop trust in the treatment team were given much credit by report writers:

he has demonstrated a willingness to engage in this process and a high degree of trust in his therapist by engaging in a distressing experience to achieve therapeutic gain (2050, 8(2) Psychologist report).

describes his time on the DSPDU as 'the hardest thing I've ever done' ... says that finding out about himself has been frightening, and it is to his credit that he continues to engage in the therapeutic process (2055, 3(3) Seconded probation officer report).

Other challenges of completing therapy on a DSPD unit were often acknowledged, with prisoners given much credit for not retaliating against other prisoners (2040, 2052) and maintaining a positive attitude and behavioural response in the face of difficulties:

He has maintained a generally positive attitude despite this having been a very difficult period for the spur on which he has located (these difficulties have

included a serious assault, the suicide of the perpetrator of the assault and ongoing tensions between some prisoners following these events) (2032, 3(1) Psychiatrist report).

***Getting to know the DSPD prison units***

One report for a prisoner based in one of the prison based DSPD unit explained that:

The treatment programme is guided by a cognitive interpersonal treatment model developed on the unit and based on an understanding of the diverse needs of prisoners meeting DSPD criteria. The programme includes weekly individual therapy and a cognitive interpersonal group, both of which are ongoing throughout treatment on the unit. Other elements of the programme are schema-focused work and affect regulation, progressing to offence related work (2052, 2(2) Psychiatrist report).

In the case of a prisoner from the other prison based DSPD unit, the psychologist identified that:

Since 4016's arrival onto the [DSPD] unit he has completed ... Treatment Needs Analysis [This] examines and explores the relationship between the personality disorder(s) and the criminogenic risk and need areas ... 4016 has also completed the Motivation and Engagement component of the Chromis programme ... [and] ... the Psycho-education domain of treatment, comprising the following courses, Introduction to Treatment, Personality Disorder Awareness, Risk Awareness and Boundary Setting component (4016, 3(1) Psychologist report).

Although lengthy assessment and treatment analysis reports were often provided to the PB, it was not always clear when these had been supplied because they are often submitted separately from the dossier. When assessment reports were submitted to the PB, they would devote some time to describing the focus of these different programmes (see Appendix E for more information regarding the clinical models at each site). The vast number of different treatment modules highlights that treatment in a DSPD unit was often presented as comprehensive:

the programme is comprehensive and has the capacity to address 2035's risk factors (2035, 3(1) Seconded probation officer report).

he will be subject to a comprehensive package and will be required to participate in groupwork ... not expected to engage in extracurricular work (2039, 3(1) Seconded probation officer report).

Often, treatment on a DSPD unit was presented as aiming to help the staff and the prisoners develop a better understanding of the participants:

2033 is currently involved in a programme that has the potential to help him develop a fuller understanding of how he developed into the person he was (2033, 5(3) Seconded probation officer report).

the work that 2035 is currently undertaking in the DSPD unit can only be helpful in extending our knowledge of 2035's risk factors (2035, 3(1) Seconded probation officer report).

2055 is making excellent progress on [the DSPD unit] and persists in developing a fuller understanding of himself as a whole person (2055, 3(3) Psychologist report).

The need to develop a better understanding of DSPD prisoners is unsurprising in light of the observation made by several report writers that these individuals had often been excluded from accredited offending behaviour programmes. One psychologist identified that:

the purpose of DSPD is to address the needs of those who previously have been excluded from offending behaviour courses (4005, 2(1) Psychologist report).

What was less clear was where DSPD treatment may fit with other accredited offending behaviour programmes available in the Prison Service:

while they are participating in the DSPD program, prisoners are not expected to participate in other offending behaviour programmes ... in the foreseeable future participation in the programme will effectively be his sentence plan (2035, 3(1) Seconded probation officer report).

In the report for one prisoner, the difference between DSPD treatment and more traditional approaches was made more explicit:

the groups differ from traditional prison offending groups in as much as they are not structured and do not have an agenda. The absence of structure allows for increased levels of affect in the groups as the prisoners have to work with the raw emotions about themselves and their offending interpersonal styles. The

content of the group is generated by other prisoners and is generally focused upon activities on the wing and the prisoners observations of their behaviour and relationships. The prisoners find these groups very difficult due to the high levels of affect, use of explicit communication and inability to take emotional responsibility for their behaviour. The group is facilitated by both clinical staff members and operational staff (2056, 4(3) Psychologist report).

An independent report for one participant, considered to be progressing well, teases out some of the links between DSPD and other accredited programmes:

The DSPD programme takes a broader and more holistic approach to the treatment of risk factors, much of which overlaps with (but goes beyond) other accredited programmes. It is therefore reasonable to conclude that the programme has covered much of the material of other programmes. More specifically, the work on schemas and developmental experiences overlaps with the focus of the extended SOTP (2055, 3(3) Independent psychology report).

### **Getting out of the DSPD prison units?**

In the main, prisoner attitudes towards DSPD, parole and the future were not raised in the reports, with very few participants having submitted written comments to the PB. Where their views were raised by report writers, a mixed picture emerged. One Parole Board interviewing member's report observed:

I asked what he had felt reading the [DSPD assessment] report. He responded by saying that he felt "stupid". He explained that this was because it had been stated in reports at Crown Court that he is not treatable and he had come to prison for punishment. Now, other reporters are saying that he is treatable and he thus feels stupid that he submitted himself to have such assessment ...



asked his opinion of the DSPD, 2057 described it as 'childish' because he had been required to do painting by numbers and making tea towels. Was any aspect of the unit of positive value? He said not. Having signed himself out of the unit ... he had subsequently considered returning but now he is resolved not to enter the intervention programme. He is certain that he does not have a personality disorder (2057, 3(3) Parole Board interviewing member report).

The first part of this quote reveals the double-bind that some DSPD prisoners may feel they are in. In stark contrast to the report above, an independent psychology report for another prisoner undergoing his third PB review since DSPD admission identified:

2055 fully acknowledged the type of prisoner that he had been previously, and also spoke positively and warmly of his time in the DSPD unit. He found his individual therapy particularly helpful (2055, 3(3) Independent psychologist report).

Prisoner views regarding progression and parole also appeared to be mixed. This suggests that the prisoners may struggle to know what their futures look like, and how to respond to this uncertainty. The reports for one prisoner who had spent over twenty-seven years in prison serving a life sentence for arson with an eight year tariff, observed that he:

gave contradictory accounts of how he will spend his time at [the DSPD unit]. On the one hand he was looking forward to the future and wishing to complete the necessary work here with a view to eventual release through a hospital setting. However he has told me that he has definite plans to commit suicide and has set a date ... described himself as a Duracell battery ... felt he was eventually 'running out' ... I gained the impression that he was running out of

hope of release and he tells me he finds it difficult to even care about himself (2048, 10(1) Seconded probation officer report).

This suggests that a small number of participants were particularly institutionalised and nervous about progression and the chance of a life outside. The records for one determinate sentenced prisoner identified his anxiety about a progressive move:

2044 can at times still have some difficulty interacting with others. This could cause friction with people who do not know, or for that matter, care about his past condition and his stay on the DSPDU. If he is out of the protective environment of the unit others could react in a negative way to his behaviour and thus a situation could escalate and cause him problems. He appears to me to be scared of such a scenario coming true and has told me that he does not want parole this time round (2044, 1(1) Personal officer report).

These statements suggest that prisoners had mixed views about whether they wanted parole. They also support Cohen and Taylor's (1972) observation that some long term prisoners see their chances of parole as nil, and therefore not a 'reward' stage. Prisoners also appeared to hold different views about the purpose of their parole review. The seconded probation officer for one prisoner reports:

He told me that he did not wish to be interviewed. His view was that he would not be considered suitable for parole and therefore saw it as a pointless exercise (2047, 4(1) Seconded probation officer report).

In contrast, the reports for another prisoner identified that:

Until recently 2052 refused to accept post or letters for fear of contact with his family but has sought the assistance of legal representation and is actively working towards parole. This is a big step for 2052 (2052, 2(2) Personal officer report).

It was apparent from a few reports, that staff make assessments about the motivation of prisoners towards treatment and transmit this to the PB. The dossier for one prisoner noted that:

4024 indicated that he was willing to address his offending behaviour and was motivated to attend the course, however it was later established that his motivation for doing so was to impress the Parole Board (4024, 2(1) Summary of progress in prison).

The reports of another prisoner noted that:

the report writer stated that it was therefore difficult to determine whether 2030 viewed his offence focused work as a vehicle for attaining lower security conditions or as a means of reducing his risk of causing harm to others (2030, 5(1) Summary of progress in prison).

This indicates that report writers send clear messages to the prisoner and the PB, and may use the review to encourage prisoners to take responsibility for their future progression:

He does need to realise that as a life sentence prisoner the onus is on him to demonstrate that he has addressed his risk factors through offence focused work .... Having a problem with alcohol or coming to terms with being abused

as a child are not valid arguments. Until he can show that he understands this and makes the appropriate changes there is in my opinion very little prospect of him progressing towards open conditions or release in the foreseeable future (2047, 4(1) Seconded probation officer report).

In contrast, some prisoners were presented as having taken more responsibility for their offending behaviour. The seconded probation officer's report for one prisoner commended him because:

2040 is evidently not willing to pay lip service to the concept of "insight" in order to fulfil the parole criteria (2040, 4(2) Seconded probation officer report).

These statements suggest that report writers are keen to try and encourage participants on their journey through DSPD services, and to re-iterate to them that they need to make genuine progress, before a progressive move will be considered. It was apparent however, that several prisoners were anxious about where DSPD fits with accredited offending behaviour programmes, and how their DSPD placement would be perceived by the PB. The reports for one prisoner, observed that:

4005 has expressed anxiety over these courses not being 'recognised' or 'accredited' for example, by the Parole Board and because of this does not feel that they will help him in the future (4005, 2(1) Psychologist report).

The reports for another prisoner noted that:

He said that he was frustrated because he has not been able to address his risk factors in the same way that other prisoners do through accredited programmes (2056, 4(3) Seconded probation officer report).

This illustrates that progression may mean different things for the prisoner, the unit and the PB. Anxieties about the status of treatment on a DSPD unit, led some participants to request transfers back to 'normal location' in order to undertake accredited offending behaviour programmes. For one prisoner undergoing his third PB review in DSPD, the PB interviewing member's report recalled that when:

asked what he is hoping to gain from this review, 2057 was clear that he is seeking a transfer, both for his father's sake by a move closer to home, and to enable him to attain a location that will meet his needs, specifically a SOTP opportunity (2057, 3(3) Parole Board interviewing members report).

The home probation officer in another case noted that the prisoner:

expressed frustration that he is still on the DSPD unit and expressed the view that the therapy he has previously received is, ten years on, 'now worth nothing' ... he indicated that his biggest hope was to be removed from the DSPD unit and get back into 'the system' (2033, 5(3) Home probation officer report).

Others were recorded as anxious about the time taken to commence assessment.

One prisoner was reported as having:

expressed frustration and disappointment at the time it is taking to commence the [DSPD] criteria assessment (4005, 2(1) Lifer manager report).

In the review of another prisoner the PB interviewing member identified that:

As a general concern 4016 wished the board to note, he explained that he is now in his seventh year of sentence and has been subject to 'assessment after

assessment after assessment' yet he has not actually been afforded any actual treatment to date, despite being highly motivated throughout (4016, 3(1) Parole Board interviewing member report).

Prisoners were also reported as having expressed concern that the length of the programme had changed, and were anxious that it would continue to increase (2056, 4(3) Seconded probation officer report). These concerns about assessment and treatment highlight that 'time' and visible progressive benchmarks are important for DSPD prisoners, and supports previous research with DSPD patients that has identified:

a pressing need for clearer timetables around anticipated lengths of stay and likely treatment pathways. This is a crucial component of therapeutic trust and realistic hope (Maltman et al, 2008:15-16).

The significance of visible benchmarks of progression is also highlighted by the issue of the security category of DSPD participants. Informally I was advised that Category A prisoners are not usually recommended for a downgrade to Category B until they have completed the offending behaviour work identified by their life sentence plan. However, the time involved with DSPD assessment and treatment means that participants may be waiting a long time for a positive recommendation in regard to security classification. This was a source of frustration for some prisoners:

[he] remains a category A prisoner and this causes some disquiet as he sees it as a lack of recognition for the progress he has made (2040, 4(2) Seconded probation officer report).

The issues presented by security categorisation are well summarised by a solicitor's letter included in a dossier for one participant:

2046 is unusual in that he is participating in the DSPD unit ... which is not based around standard accredited offending behaviour work and is therefore outside the usual parameters for judging reduction of risk ... the categorisation system is particularly ill suited to the assessment of DSPD prisoners. Whilst in practice, recategorising 2046 will have little bearing on his day to day life or the security with which he is held, the success that re-categorisation would represent would be a mile stone in recognising and reinforcing his progress in the DSPD unit. Similarly, there are many Category A and life sentence prisoners engaged in the DSPD unit. They need to be aware and to see that continued engagement in the DSPD unit will be recognised by the Category A committee (2046, 6(3) Solicitor's letter).

These statements highlight that risk management involves rewards (Duggan 2007; Mullen, 2007), and that visible benchmarks and signs of progression are important for the management of DSPD participants. They also suggest that DSPD progress needs to be recognised and rewarded in order to encourage motivation. The Independent psychologist report for a Category A prisoner undergoing his third PB review in DSPD identified that:

In terms of a way forward it is my view that it is now time for 2055 to see that his considerable efforts are going to be rewarded by clear and visible signs of progress through the system (2055, 3(3) Independent psychologist report).

Unfortunately, however, the progression routes for DSPD prisoners were largely unclear from the reports. This may explain the high level of caution amongst report writers in evidencing risk reduction. The reports for one prisoner identified that:

At the present time community provision for offenders with personality disorder is very limited but it is hoped that by the time 2020 is ready for release that there will be greater provision for both psychiatric and social support (2020, 8(1) Psychiatrist report).

For another prisoner, it was noted that:

So far there is no defined path for progression for life sentence prisoners who have completed treatment on the DSPD unit but plans are being developed for suitable progressive placements in Category B establishments. It is hoped that 2040 will achieve re-categorisation on evidence of sustained progress and that he will be suitable for a progressive move on completion of treatment. In view of his current situation it is too early to make any specific recommendations in relation to his needs for rehabilitation or supervision ... in general terms I consider that any prisoner meeting DSPD criteria should in future have access to supervision by a forensic mental health team with experience of management of offenders with personality disorder. At the present time such services are very limited but it is hoped that they may be more readily available when relevant for 2040 (2040, 4(2) Psychiatrist report).

For one determinate sentence prisoner undergoing his first PB review, the seconded probation officer notes:



He is asking for a high level of support to assist his reintegration. I understand that options are being explored for the most suitable place to which to refer 2044. This, as ever is being hampered by resource issues (2044, 1(1) Seconded probation officer report).

These statements remind us that the success of the DSPD units is dependent on prisoners being able to progress to appropriate facilities in conditions of lower security and the community. This is reliant on the willingness of professionals in lower security services to take DSPD prisoners, and on appropriate resources being made available. In one case, an independent psychologist (with considerable experience of working with offenders with personality disorder), suggests three options for progression. The first is a fast track to the community via open conditions, with respect to which the psychologist notes:

I do not favour this approach, as it has previously been a criticism of the Grendon regime, that great strides in treatment are subsequently lost, and prisoners fail to recover from the 'loss of the therapeutic facility' (2055, 3(3) Independent psychology report).

The second is to return to normal location, moving towards lower security prisons, where prisoners can undertake the Extended Sex Offender Treatment Programme (ESOTP) and Healthy Sexual Functioning (HSF) courses. This approach may also raise problems, in that several prisoners were reported as anxious about returning to 'normal location':

2048 consistently voices future concerns about leaving the DSPD unit and has intimated that a secure hospital setting would be the best way forward for him; he doubts he would be able to manage life away from a secure environment,

but he stated that he also cannot cope with the idea of returning to a normal prison unit (2048, 10(1) Psychologist report).

Similarly, a report for another prisoner noted that:

He was concerned that he would become overly dependent on the DSPD unit. He felt it was important for him to move on now, and that there was a danger he would become bored with the therapeutic process. However he recognised that he continued to need a good deal of support, and he was appropriately anxious about a move into the mainstream Prison Service (2055, 3(3) Independent psychology report).

The third option proposed by the independent psychologist, which appeared to be the preferred approach, is a transfer to a medium secure unit within the mental health service. This however, is likely to be restricted by resource issues, as the reports for one determinate prisoner highlight:

2044 will be referred, prior to release to the Henderson (an organisation that treats people who have personality disorders). At the time of writing this referral has not been made and it is important to note that due to reasons of funding it is unlikely to be successful (2044, 1(1) Home probation officer report).

This suggests that despite the improved behaviour and engagement of most DSPD prisoners, the future remains unclear. It was also apparent, that the futures of DSPD prisoners may be very different. For one participant, the home probation officer was keen to point out that, providing the prisoner did what was asked of him, a future in the community was not unrealistic:

4001 has acknowledged that his journey towards an offence free future will neither be a short nor an easy one ... however if he can maintain current levels of commitment to treatment regime [on DSPD] and if he can continue to work constructively with staff on the unit then it is hoped that in time ... the identified level of risk that he presents can be reduced to a level where it will be considered appropriate for 4001 to return to the community (4001, 3(2) Home probation officer report).

For others the future was identified as more bleak, with the potential of treatment limited, and progression to the community unlikely:

At the present time, the focus of treatment must be in stabilisation improvement of day to day function and improved quality of life. At the present time it seems most likely that 2046 will need to remain in a secure setting for the remainder of his life (2046, 6(3) Psychiatrist report).

Just as clearer progression routes are required for those who are expected to make progress in DSPD, so too, must clearer management plans be devised for prisoners who are expected to need to remain in a secure setting for the remainder of their life.

## **Getting on in the DSPD hospital units**

### ***Getting to know the DSPD patients***

Although at the time of admission to DSPD, one patient was detained under s37, two under s37/41, three under s47 and eighteen under s47/49, by the time of the first MHRT review for each patient, eight patients were detained under s47/49, and ten under s41(5) / notional 37. In other words, while only four patients had entered DSPD as unrestricted patients, at the time of their first MHRT fourteen of the twenty-four participants were unrestricted. This highlights that the majority of DSPD patients come

from prison (de Boer et al, 2008), and that a large number of determinate sentence prisoners are close to their Non-Parole Date (NPD) / Earliest Date of Release (EDR) at the time of transfer to the mental health system. This supports previous research that has found that prisoners are more likely to be referred to hospital as they get closer to their NPD / EDR (Grounds, 1987).

By the end of the study period, the time served since conviction for all patients ranged from just under two years to just over twenty-one years, with the average time in detention since conviction just over nine years. The time participants had spent in the hospital DSPD unit varied from one year and one day (1005) to just under four years and five months (1019). On average, patients had spent just under two and half years in DSPD.

	Prisoners	Patients
Post-DSPD admission characteristics	<ul style="list-style-type: none"> <li>• Average time in DSPD 3 ½ years</li> <li>• Vast majority reported as behaving well in DSPD</li> <li>• Majority are presented as having improved levels of engagement</li> <li>• Extent of risk reduction and progress in treatment is unclear</li> <li>• Unclear progression routes</li> </ul>	<ul style="list-style-type: none"> <li>• Average time in DSPD just under 2 ½ years</li> <li>• Far more mixed reports regarding behaviour</li> <li>• Most are described as having fluctuating engagement</li> <li>• For some patients, more information about risk reduction</li> <li>• Clearer pathways to progression</li> </ul>

**Table 5: Post-DSPD admission characteristics of DSPD prisoners and patients**

In comparison to the prisoner sample, the patients were presented as having far more of a turbulent career following admission to a DSPD hospital unit (see Table 5). The involvement of the police and the courts was also noted in the reports of at least five other DSPD patients (1018, 3020, 3023, 3028, 3030) in the sample. Significantly, one participant (3030) (along with others not in the sample) was given a restricted hospital order in response to a number of serious incidents at one of the DSPD sites, changing his section from s41(5) to s37/41.

This demonstrates that many patients had a record of aggressive behaviour, periods on seclusion, and transfers between DSPD wards. The reports for one patient explained that on one occasion:

1006 went to his room, he smashed the television that had been provided to him by [the] Hospital, presumably in order to obtain broken shards of glass. He is reported to have cut his forearms in order to have exposed bleeding sites which may affect those tasked with restraining him (he is HIV positive). He placed a liquid (shampoo) across the entrance way to his room and placed broken shards of glass upon this; the aim presumably to trip and injure those tasked with restraining him (1006, Psychiatrist report).

For another patient, a summary of one months behaviour included:

Verbal altercation with peer ... threatened to knock peer out and started walking in threatening manner towards him ... stated that he missed fighting and violence and was thinking of smashing someone's face ... abusive to staff when asked to unlock his door – told them to 'fuck off and fuck the CTM' [clinical team meeting] ... shouted at peer stating he would hit him and that he was to 'fuck off' ... requested 2 croissants for breakfast. Threatened to jump over the hatch

when informed by staff to wait for 'seconds'. Told staff they would not do anything to him and that he would take over the whole hospital (1016, Psychiatrist report).

The summary of incidents for this participant continues for many pages of his psychiatric report to the MHRT. The social circumstances report for another patient highlighted that:

Following his arrival here at the [DSPD] unit, 3024 has made it absolutely clear that he does not want to be here. There have been two episodes of self harm, one in which he was observed punching himself in the face, and one in which he inflicted numerous lacerations to his right arm in response to not being given medication (diazepam). When we discussed his self harm behaviour, 3024 told me 'it is my body, leave me alone, I will have control over my body. All the while you have control I have to take some back' (3024, Social circumstances report).

This highlights that some patients had a record of self harm, and that while patients often presented as disruptive and aggressive, many also displayed much vulnerability. This last extract also indicates that self harm can be used as a subversive tool, and that DSPD patients and prisoners may use self-harm as a means to get their own way. The reports for another patient noted:

At times his manner and tone to members of his nursing team was described as threatening and hostile. At times there were episodic hunger strikes where he would refuse food and at times fluids in addition and these would last a few days ... at the same time, his offensive and derogatory attitude towards his named nurse can change. When his named nurse was leaving the ward 3003 was reported to comment that she was 'the most important person in his life at

the moment' and also to start crying ... on the same day ... 3003 is overheard to shout inappropriately to his named nurse 'only reason you are leaving is because you can't handle my wanking' ... [a few days later] ... 3003 behaviour was such that it was deemed he was inciting other peers on the ward to group disorder (3003, Psychiatrist report).

In addition to a record of mixed behaviour, most patients were presented as exhibiting fluctuating engagement with the treatment programme. The reports for one patient highlighted that:

3028's initial progress on the [DSPD] admission ward was one of pushing boundaries and fluctuating engagement (3028, Psychiatrist report).

The reports for one participant who was described as having begun group and individual treatment sessions in a 'positive and collaborative fashion' noted that:

In approximately the third month after his CPA 1010's attitude towards his participation in group processes changed markedly ... made a rather sudden and precipitant decision to withdraw from all group work and focus instead on his individual sessions only ... expressed an opinion that he had already completed enough group therapy processes during his time in prison ... said he felt trapped in hospital because the staff would always criticise him ... also said that he would be much safer in prison because there would be nothing expected from him, and that his emotional security could be guaranteed (1010, Psychiatrist report).

The reports submitted to the MHRT, in contrast to the reports prepared for the PB, spend more time detailing individual incidents. The presence of 'more extensive

narrative accounts' and 'more detailed descriptions of incidents' in mental health files has previously been identified by research carried out in the US (Toch and Adams, 2002:101). This led to very mixed reports of both behaviour and engagement, and is captured well in one RMO report to the MHRT, in which the patient's progress in DSPD was described under the following headings:

An emerging pattern of mistrust and anxiety ... a contested Manager's hearing upheld detention in hospital ... demonstration of ability to work productively to a high standard ... continuing pattern of difficulty trusting, feeling persecuted and related anxiety ... demonstration of ability to develop trust ... a significant risk event and related pattern of behaviour that requires further reflection and understanding in therapy ... increasing insight (3002, Addendum psychiatrist report).

Several reasons were attributed to the presence of disruptive behaviour among the patient sample. Most often, it appeared that patients were resentful of their transfer into the mental health system, highlighting that 'the prospect of indeterminate incarceration may lead to even less co-operation with the system, a downward spiral of bad behaviour and an adverse effect on the therapeutic milieu' (Feeney, 2003:356). This was evident in several reports. One patient's report identified:

He is explicitly hostile to treatment in the [DSPD] centre ... It is unfortunate that the decision to admit to the DSPD services has come so late in a relatively short prison sentence. It is possible that a proposed transfer nearer the beginning of a longer prison sentence would have engendered less resistance (1016, Psychiatrist report).

The report for another patient observed:



1006 was very angry at the time of his transfer here; he had been expecting to be released from prison in December 2005 but instead found himself transferred to the DSPD unit in October 2005 (1006, Psychiatrist report).

The independent psychiatrist report for one patient noted that he:

presented [at interview] as someone who was clearly frustrated and annoyed about his detention in [name of] hospital. Talking to him about the sequence of events he confirmed that he had been admitted in March 2006 when his sentence was due to expire ... [in] ... April 2006 with him saying 'and they can't understand why I'm angry' (1018, Independent psychiatrist report).

In addition to disruptive behaviour being attributed to the late transfer of determinate sentence prisoners to the mental health system, it was of note that disruptive behaviour and ambivalent engagement were often presented as nothing unusual, and to be expected. One patient's report noted:

For the first few months 3003 was experienced as being very challenging with nursing staff ... he was noted to be engaging with groups and ward activities though on occasion he found it difficult to remain focused. Generally this was seen as a testing of his boundaries which is frequently encountered when patients test out an unfamiliar or new ward environment (3003, Psychiatrist report).

Similarly to the reports submitted to the PB, improvements in behaviour and motivation for treatment were most often attributed to the physical, procedural and relational security of the DSPD units. The psychiatrist for one review noted:

In protective environments such as [name of hospital] DSPD unit, with its clear structures and boundaries, with experienced and trained staff on hand to deal with issues as they arise, there has been no significant or overt aggression. However I would argue that this is largely because of the protective environment and trained staff (1005, Psychiatrist report).

Improvements in the behaviour and engagement of patients also appeared to follow the realisation that treatment in a DSPD unit may represent their last opportunity to engage in treatment, and their best chance of progressing towards release. That some patients feel like this has already been identified through qualitative research with patients at one DSPD site (Maltman et al, 2008):

1010 described quite clearly to me his history of fluctuating attitudes towards therapy and to the hospital programme, bearing in mind that he has requested to return to prison. Acknowledges that he feels apathetic at times and very withdrawn from others. Told me that he holds a background belief that his life is not over, whereas before – in prison – he believed it was. Considers that the work done here so far has enabled him to 'have a chance'. Complicating this however is a recurring worry that he will never be discharged or released and will die inside an institution of some sort (1010, Psychiatrist report).

The views of one participant submitted to the MHRT highlight how patients may come to realise that engagement in the programme may aid their progression to lower security and the community:

Since my admission to the DSPD unit ... I have refused all forms of therapeutic and non-therapeutic groups. My main reason for this rather foolish decision was that I did not trust, like or respect any of the staff that work here. After a rather

lengthy period of reflection and a keen willingness to progress through the system, and eventually return to the community outside of this place, I have decided that the only way to gain this progression is to actually actively undergo therapy (1018, Care Programme Approach (CPA) report).

Like the PB reports, the MHRT reports spent much time outlining all the key risk factors that had been identified by a range of risk assessments. Attention was also given to evidencing that the MHA 1983 and DSPD admission criteria had been met. In comparison to the reports submitted to the PB, the MHRT reports spent more time tackling the issue of risk reduction, often making reference to the fact that patients had been regularly assessed using the VRS and/or the HCR-20:

The VRS is currently reapplied every 12 months although can always be done sooner should the individual case dictate, and the stages of change and amount of change can be measured using this instrument. It should be borne in mind that these instruments are not infallible, but they serve as a useful guide to clinical judgment and are helpful in setting clear goals and realistic tasks for the patient to achieve as they progress along their treatment package (1005, Psychiatrist report).

In the case of another patient, the psychiatrist outlined that:

1008 has been reassessed with VRS for purpose of CPA in Feb 2006. Overall results indicated there was an improvement and that this improvement had been maintained since admission. This is especially so regarding the criminality factor and the sexual deviancy factor as well as an improvement in the area of substance abuse. ... In readiness for his Sept 2006 CPA his risk profile was reassessed using the HCR20. This indicated that the 'clinical' and 'risk

management' items had not changed, though raters had identified some presence of deterioration in score in the categories of 'unresponsiveness to treatment' and 'non compliance with mediation attempts' ... Considered that these altered scores reflect his overall reduction in attendance and engagement in therapy programmes (1008, Psychiatrist report).

DSPD was presented as an appropriate placement by all report writers, except those who advised that a transfer to conditions of lower security would be appropriate. One probation officer's report to the MHRT identified that:

Many of the professionals working with 1016 have noted that his behaviour results in cycles of release – re-offending – custody – and despite our best efforts our interventions have not impacted on 1016's behaviour or rehabilitation ... I cannot see any way to break this cycle unless he receives the proper care and treatment in the DSPD unit (1016, Probation letter submitted to MHRT).

That DSPD is an appropriate placement was also evidenced by the high risk that patients were assessed as posing, with attention to both historical and current behaviour. In the case of one participant, the social circumstances report noted that:

Although significant progress is being made, it was only nine months ago that 3016 secreted a pool ball and told staff that it had been his intention to use it to kill a patient. Very recently he has seriously assaulted a vulnerable patient ... in general 3016 has made significant progress but continues to display problematic behaviour ... Continued detention in a high security setting is justified due to the risk of deterioration in a less heavily supported setting .... I am aware that the clinical team are anxious that the progress he has made is

not jeopardized by asking too much of him too soon (3016, Social circumstances report).

This highlights that in many respects, several of the MHRT reports followed a similar pattern in that they would highlight the potential for 'risky' behaviour even within the high security setting of DSPD, most often balanced with evidence that the patient met the criteria of the MHA 1983 in that they required high security and were benefiting from treatment. This highlights that hospital report writers are required to justify detention in DSPD and anticipate the issues that may be raised before the MHRT:

1016 presents a number of treatment targets which are dealt with by DSPD services and he has neither been offered or taken part in any intensive long term therapeutic programme ... it is thus far from certain that entry into a DSPD programme would fail to alleviate or prevent deterioration ... when concerns about his resistance and lack of engagement in a DSPD setting are weighed against the extremely high likelihood of continued antisocial behaviour and sexual offending when at liberty, despite close supervision, it is arguable that it would be appropriate to assess 1016's suitability for the programme during an adequate trial of treatment (1016, Psychiatrist report).

In some reviews, particularly where the issue of treatability appeared to be in doubt, report writers devote much attention to the services on offer in the hospital DSPD units. Several reports submitted to the MHRT made it clear that if the patient was to be discharged to the community, or even a lower security unit, they would pose a very real risk of harm to others. One psychiatrist observed:

3020 does not have an extensive forensic history but it is evident that he has committed numerous violent acts for which he has not been convicted ... his

violent behaviour has persisted within a custodial setting and indeed, whilst he has been a patient in the [DSPD] unit ... 3020 was convicted of assaults and racially abusive behaviour against staff members in November 2005. There has been no offence related work undertaken with 3020 whilst he was in the prison system nor since his admission to the [DSPD] unit. Thus given the unpredictable nature of his violence and indiscriminate targeting 3020 continues to pose a high and ongoing risk (3020, Social circumstances report).

These observations indicate that violent behavior while in detention, the absence of offending behaviour work and unpredictability are used to justify placement in DSPD. Additionally, these statements suggest that like the prisoners sample, many patients had difficulties in trusting staff, and as a result were presented as something of an unknown quantity:

1019 has not shared with me directly his life journey and story and our professional relationship is still forming. Consequently I regret that I am not aware of 1019's own view of his continued detention. However, he has spoken about the time that he feels he needs to continue with his treatment and future resettlement in a step down or any other facility (1019, Social circumstances report).

The reports of another patient identified that:

Generally cautious and suspicious with his interactions with staff and limited in the information that he wished to give about himself, preferring to seek advice from his legal representative ... seemed more concerned that staff team were trying to trap him and extend his time in detention away from community (1005, Social circumstances report).

***Getting to know the DSPD hospital units***

The reports submitted to the MHRT were often lengthy and, like the reports submitted to the PB, devoted considerable time to outlining the risk factors identified by DSPD assessment. Often too, the reports would list the treatment modules that patients had undertaken, or were recommended to take. The reports for one patient, who had completed a large amount of treatment on DSPD (and was later given a MHRT recommendation for discharge) noted that:

He has participated fully in our comprehensive Cognitive Behavioural Therapy Programme both in terms of individual and group work. He has completed successfully the following programmes: introduction to therapy, introduction to CBT, considering change, social skills, my life, now and in the future, stress and emotion management, anger management, enhanced thinking skills, anti-bullying, empathy enhancement, psycho-education, CALM (Controlling anger and learning to manage it), situations review, dress rehearsal, attitudes, consolidation programme, costs and benefits, alternative thoughts, dilemmas (1001, Psychiatrist report).

One of the reports for a patient detained in the other hospital DSPD unit explained that:

The DSPD programme is a pilot service to address the psychological and interpersonal difficulties of recidivist violent offenders in a manner which is hoped will decrease the damage these people do to others and to themselves. The patient group served by the DSPD programme are often difficult to treat, needing enhanced programmes and previously would have been thought untreatable by other services (3028, Psychiatrist report).

It was apparent, that in addition to outlining the treatment approach in DSPD, report writers also responded to the 'political' aspects of DSPD. In the case of one patient, who was later returned to prison on the basis that he was not engaging in treatment, the RMO noted in his lengthy report, that:

[IP] in his report to the Tribunal states 'the role of the mental health system is to be therapeutic and not to act as a backstop for the criminal justice system in respect of preventive detention'. I agree with this statement. The DSPD service is not a preventive detention service. If the government wished to have a preventive detention service they could do so more cheaply than the cost involved in the DSPD service. The DSPD service is a treatment service which improves the quality of lives of patients suffering from personality disorder, addresses risk factors and assists those around the patient who suffers from personality disorder (1020 Psychiatrist report).

In another case, where the MHRT was presented with IP reports that contradicted the RMOs assessment, the addendum report from the RMO noted:

There are no longer the old nihilistic attitudes and opinions that have individuals with personality disorder, notably antisocial personality disorder, as being untreatable and therefore excluded from services. There is an impressive body of evidence compiled over the past 10 years which lends support to the premise that programmes addressing criminogenic need in offenders do contribute to the management and the reduction of risks. Such programmes undoubtedly include offenders with personality disorder ... the effectiveness of this service over long term can be seen in the statistics for 3004. The graphs for violent behaviour since admission and sexual behaviour since admission show improvements ... further evidence of effectiveness of DSPD services is shown



by the number of patients being rehabilitated from a high secure environment and now able to be managed in a lower secure environment (3004, Addendum psychiatrist report).

In this case, the RMO cites several research findings to support his view that DSPD services can be effective in the management and treatment of DSPD patients. In the same case, the RMO made the important observation, drawing from Howells et al (2007) that:

As stated by [IP] 3004 is in a state of complete denial about the vast majority of his identified abnormal personality traits. He demonstrates little insight into his condition and a reluctance to change ... The issue is no longer that if someone is in complete denial, and therefore demonstrates poor insight and poor motivation that they are regarded as untreatable. The current thinking is that denial, poor insight and poor motivation are treatment targets that require interventions to improve recognition, insight and increased motivation ... 3004's position is neither unusual nor something that the unit cannot cope with and it is an expected difficulty along the treatment pathway (3004, Addendum psychiatrist report).

The implication of this research, as presented by the RMO, is that DSPD services have the potential, as well as an explicit intent, to address the 'enduring irony of treatment' previously highlighted by Grant (1999). It is of note that in this case, an independent psychology report was submitted to the MHRT citing a number of research studies that presented a more pessimistic view about the treatability of individuals with personality disorder. This highlights that where treatability was in debate, academic articles were often cited and/or actually submitted to the MHRT by both the unit and independent psychiatrists, as they engaged in debate about the evidence concerning the likely

treatment success with DSPD patients. It is also of note that although the reports spent much time outlining the evidence regarding the treatability of DSPD, little reference was made to traditional treatment programmes. This may highlight the more flexible and individualised structure of treatment in the mental health system.

### **Getting out of the DSPD hospital units?**

It was apparent that some patients were angry about their detention in DSPD, with several seeking a MHRT discharge back to prison or to the community. The medical report for a patient who had been transferred into DSPD two days before his NPD, explained:

On arrival at the DSPD unit 1005 was understandably aggrieved. He had been close to the end of his sentence and had not been expecting transfer into the hospital system ... he said he found himself in somewhat of a double bind ... he felt that were he to co-operate fully with the treatment package at the DSPD unit he might weaken his appeal to the Mental Health Tribunal by demonstrating he was treatable, when in fact it may be more advantageous to what he wished to achieve to refuse to co-operate, be deemed untreatable, get discharged and then seek some form of treatment on an outpatient basis (1005, Psychiatrist report).

This clearly demonstrates the double-bind that some DSPD patients may find themselves in when deciding whether to present as knowable or unknowable, and whether to engage with DSPD treatment. Other patients presented as frustrated by their journey into DSPD services. The following extract from a letter by a DSPD patient was submitted to the MHRT:

In December 2003 I was given a 5 years sentence ... for 2 charges of indecent assault. During this sentence ... a letter came from Social Services stated I had been diagnosed with a psychopathic personality disorder ... As a result I was transferred to the [a prison DSPD unit] ... I was then told that I had not been transferred to do the SOTP Core and SOTP relapse prevention but to be assessed for DSPD ... 11 weeks short of the end of my custodial period I was transferred under section 47/49 to [a hospital DSPD unit] ... When my sentence expired I was sectioned under s37 [sic] as an unrestricted patient ... During my sentence I had a sentence planning board, the DCR1 stated on the risk of my offending as medium ... however, once the letter from [social services] was received the RM2000 was used again and my risk came back as high. How can this be if the same information had been used against the same statistical facts and give a different risk level? I believe that this justification to the point I have now been in custody since ... 2002. I have been prevented from doing anything regards my addressing my offending behaviour ... It has been stated in my reports that I lack insight into my offending behaviour, I have no empathy towards my victims and show no sign of remorse. First off, I have not had the opportunity to discuss these points with anyone so it is purely speculation. They have again written this as a justification to the point. Nowhere in the reports, documents, referrals or CPA reports is it acknowledged that I have not been permitted to do anything about these issues. Yet nearly every single one points out that I haven't done it. It actually reads as though I have refused. I have a placement reserved at a specialist supervised resettlement unit ... there I will be given the chance to undertake SOTP courses. But these people believe that total secure accommodation in maximum security hospital, being treated for an illness, I don't have is more appropriate. There is no record of this diagnosis previously given whilst here, as prior to me coming here I have never been admitted to [a high security hospital]. Seeing as all this stems from one

letter I disagree that I should be here. I would like to be released immediately, even if only to the [resettlement unit in the community]... as a stepping stone, as I have now been locked up for almost 4 years of a 5 year sentence. None of this was mentioned in Court (3003, letter submitted to the MHRT).

In contrast, some patients did not seek a discharge from the MHRT and did not dispute their placement in DSPD. The psychiatric report for one patient who had not applied for a MHRT but had been directed by the Home Secretary in accordance with the MHA 1983, noted:

1008 also reminded me that the hearing as it is arranged is a directed one rather than one he has sought ... he is accepting of its statutory nature but considers it nevertheless to be redundant. He made it clear at the beginning of our interview that he is not presently seeking discharge and wishes to remain in this unit where he is actively engaging in a therapeutic programme (1008, Psychiatrist report).

It was clear from some reports of the importance of MHRTs for encouraging patient engagement and hope for the future:

His therapist feels that applying to the Tribunal is evidence of him thinking positively about his future rather than believing it will be spent in an institution (3016, Social circumstances report).

This excerpt suggests that MHRTs have the potential to encourage participant engagement in the programme, and was highlighted in the reports of another patient undergoing his second MHRT since DSPD admission:

1015 had declined to participate in therapeutic sessions before his 2006 Tribunal hearing. His treating team were aware at this time of his stated view that he would engage in therapies offered to him in the event that his appeal should be heard unsuccessfully. In the event 1015's detention was upheld, and since that time he has engaged in therapies (1015, Psychiatrist report).

The importance of external professionals offering their clinical view about the progression of DSPD patients, was also evident in the reports for another patient:

Despite 3002 having completed only the initial introductory treatments I felt it would be beneficial for him to hear from an independent party about his suitability for medium security (3002, Psychiatrist report).

Where patients had exhibited disruptive behaviour and the clinical team did not support a progressive move, discussion about the patient's next placement was largely absent from the reports. It was apparent that some DSPD patients were anxious about their future progression. A few patients, especially those transferred from prison, still appeared to view their progress in the context of completing accredited programmes. The reports for one patient noted:

He said he was trying to get a career behind him and his solicitor thought that SOTP would be better than the DSPD unit (1013, Psychiatrist report).

It was apparent that some patients were frustrated about repeating treatment. One patient was reported as saying that:

He considers that he has already completed some of this work when he was at HMP Grendon (1015, Social circumstances report).

Patients were also reported as anxious that they would get 'stuck' in DSPD treatment services, with the psychiatrist in one review making the observation:

While the treating team can understand 1020's concern that 'nobody has been discharged yet' from the ... DSPD unit, that is not unexpected at this stage, and is not an indicator that there will be no discharges in the coming months and years. Clearly the service exists in order to help patients manage their symptoms, behaviours and lives in a healthier, safer, fashion and its purpose is to progress patients back towards safe, independent living. Without discharges there would be limited point to providing the service. 1020's level of engagement and how well he does in therapy will be important deciding factors in how quickly he would be referred onto conditions of lower security, and from there to the community (1020, Psychiatrist report).

This highlights that patients are held responsible for their own progression through DSPD services. In another case, the report writer noted that:

In early 2007 he was referred to a medium secure unit, but unfortunately ... he learned that he was not suitable for transfer to lower levels of security. The assessment noted 3028 fabricated a story to rationalize his behaviour. 3028's pattern of fabricating stories undermines his chances of being accepted to lower security (3028, Psychiatrist report).

Several reports for those patients who were recorded as having made progress, but not yet ready for a progressive move, mentioned that a dialogue had been opened with medium secure units about their future progression:

At this stage we are considering whether 1006 could continue the work that needs to be done in conditions of lesser security and I have opened discussions with his catchment area medium secure unit, for their assessment of his case with regard to being managed in conditions of lesser security (1006, Psychiatrist report).

It is of note that those reported as having made a consistent effort and progress with DSPD were found to have positive recommendations by the MHRT. This is a positive observation in that those who engage in the hospital based programme are already being given the opportunity to move towards services in medium security and the community. For one patient, the psychiatric report identified:

1022 has done well in this setting. He is well engaged and a keen participant in the overall treatment programme ... it is the view of the treating team that 1022 may be manageable in conditions of medium security, particularly if he continues to have strong motivation to engage in therapy (1022, Psychiatrist report).

For another patient who was later given an absolute discharge to the community by the MHRT, the psychiatrist identified that:

The unanimous opinion of the Clinical Team ... is that 1001 has made significant progress since his admission to the DSPD Directorate and that the treatment targets identified at the beginning of his admission and referred to earlier in the report have either been achieved or are near achievement and as a consequence his risk of reoffending has decreased significantly (1001, Psychiatrist report).

## **Conclusions**

Overall, the reports submitted to the PB and the MHRT present placement in a DSPD unit as appropriate, and in the case of patients, legal under the MHA 1983 (see page 174 for more details of the legislation). Participants were depicted as benefiting from the intervention, evidenced by a reduction in aggressive behaviour, better relationships with staff and peers, and for some, an increasing ability to engage with treatment.

Nearly every prisoner was presented as having made progress in terms of their behaviour, and for many, an increasing insight and ability to engage. In contrast, the behaviour and engagement of patients was presented as far more mixed, with the majority presented as having struggled to settle into their DSPD placement. This demonstrates that patients and prisoners may adopt a range of modes of adaptation during their time in detention. That patients react in such a way to DSPD hospital admission is perhaps unsurprising, in that they are 'exposed to uncertainty and fear for their own future, as well as fear of other patients deemed dangerous and severely personality disordered' (Daffern and Howells, 2007:31; see also Maltman et al, 2008). Moreover:

they may experience frustration generated by restrictive conditions in which they are subjected to observation and scrutiny by staff, distress and anger (particularly if they were close to definite release from prison, and as a result of social labeling). These factors may act as background stressors, priming patients for aggression by reducing their ability to tolerate the demand for participation in assessment and treatment (Daffern and Howells, 2007:31).

It was of note that those who exhibited particularly disruptive behaviour had often been transferred from prison towards the end of a determinate sentence, or recalled to hospital from prison on an original restricted hospital order. These strategies of



adaptation remind us of the importance of expectations, and that co-operation in institutional settings is dependent on perceptions of fairness and legitimate treatment (Liebling, 2007; Sparks et al 1996). When patients were reported as not engaging, report writers often presented this as an expected challenge for the units, rather than evidence that the patient is untreatable, or that DSPD treatment didn't have the potential to work. This highlights that:

Non compliance with the assessment process, or refusal to engage with treatment will not in itself constitute a reason to hold someone back from admission ... work on motivation and engagement will form a key part of the assessment and treatment process. Considerations of need and public safety should remain primary in considering and prioritising admissions (DSPD Programme, 2005a:12).

Improvements in behaviour and engagement were often attributed to the relational, procedural and physical security of the DSPD units, highlighting that the DSPD units have been identified as reminiscent of Goffman's 'total institutions' and Bentham's 'Panopticon', in which, 'the feeling of being constantly watched leads one to a kind of self regulation' (Freestone, 2005:456). Improvements in behaviour were also attributed to the realisation on the participant's part that DSPD may represent the last and/or only opportunity to complete offending behaviour work, and progress towards the community. This highlights that:

[t]he hope is that gradually, for DSPD people, the recognition of the need for treatment and the motivation to engage in treatment will grow during detention – perhaps fuelled by a realisation that there will effectively be no way out until there is a real reduction in the risk that they present, and that the only way to achieve this will be engagement in treatment (Morris, 2004a:208).

DSPD participants were often presented as something of an unknown quantity, highlighting that they have often been excluded from treatment programmes, and constitute a population who have often presented as not wanting to engage in treatment. A lack of motivation to engage in treatment has now become an explicit treatment target, and as a result, increasing pressure and responsabilisation is being placed on those placed in DSPD to develop trust with the treatment team if they wish to progress. It is suggested that DSPD patients and prisoners may have to navigate a difficult balance between becoming known and remaining unknown. If they refuse to engage, thereby remaining unknowable, they have been regarded as inevitably high risk. Yet, when they have engaged and presented as knowable, their engagement has been treated with scepticism. DSPD patients, particularly those originally serving a fixed sentence in the prison system, face an extra double-bind about whether to present as knowable in the mental health system. By presenting as knowable, and in legal terms as treatable, DSPD patients may increase the time that they serve in detention. It is unsurprising then that many have wished to be unknowable. The uncertainty that surrounds their investment in DSPD services is likely to add to these dilemmas, particularly if visible benchmarks and routes for progression remain unclear. While the reports to the PB highlighted improvements in behaviour and engagement, the extent to which treatment was working, how risk may have been reduced, and future placements for DSPD prisoners, were less clear. A focus on the day to day behaviour, however, may be helpful in the long term for evaluating the success of the treatment programme (Hobson et al, 2000).

In contrast to the PB reports, the MHRT reports appeared more comfortable with the issue of reduced risk, often detailing changes in VRS or HCR-20 scores, and noting that discussions had been, or were in the process of being, made with services in lower security facilities. Although hospital report writers are still cautious before recommending transfer to a medium secure unit, it is apparent that DSPD hospital staff

are aware that treatment can continue in lower security facilities. The caution of the prison units to assert that they have been successful may indicate that they are anxious that treatment post DSPD may not be available, especially if the prisoner is returned to 'normal location'. As a result, staff in the prison units may feel that they need to complete as much treatment as possible, before recommending a progressive move.

It is important to consider what impact the uncertainty that surrounds DSPD treatment and progression may have on patients, prisoners, DSPD staff, the PB and the MHRT. While patients are presented as frustrated by their journeys into DSPD, their routes out of DSPD appear clearer. In contrast DSPD prisoners are presented as motivated to complete treatment in a DSPD prison site, yet progression pathways remain largely unknown.

It was apparent that PB and MHRT may be used by the DSPD units to encourage engagement and continuing participation in the programme. It was evident from the reports that clear messages are sent to the participants and the PB and MHRT about progress and the viability of a progressive move. Messages are also sent to PB and MHRT members about what the report writers believe their decision, if it is to be responsible, ought to be. How these messages and the presentation of DSPD patients, prisoners and units, may impact on the decision-making and outcome of PB and MHRT reviews will be considered in the two chapters that follow.

## 7. DSPD and Parole Board decision-making

*We will be absolutely sure before we release*  
(Chairman of the Parole Board quoted in BBC, 2006).

### Introduction

Previous chapters have considered the journey of prisoners prior to and following their admission to DSPD services, as presented by the information submitted to the PB. This chapter, drawing from analysis of the written reasons provided by the PB and semi-structured interviews with PB members, explores the significance of DSPD for PB decision-making. In particular, the chapter considers the sense that PB members make of DSPD and the purposes of a PB review with DSPD prisoners. It is argued that, while no DSPD prisoner in the sample was recommended for open conditions or release, the PB review for DSPD participants can still serve many purposes. The chapter also explores the importance of prisoners undergoing a journey during their time in prison, but suggests that the introduction of DSPD services and the uncertainty that surrounds them disrupts PB conceptions of what a normal journey through the Prison Service looks like. This raises problems for decision-making about DSPD prisoners in the future.

### The Parole Board

The PB was first established in England and Wales in 1968 under the Criminal Justice Act of 1967, although its powers and procedures have subsequently been amended by the Criminal Justice Act 1991, the Criminal Justice and Public Order Act 1994, Crime (Sentences) Act 1997 (C(S)A, 1997), the Parole Board (Transfer of Functions) Order 1998, Powers of the Criminal Courts (Sentencing) Act 2000, and the Criminal Justice Act 2003. Significant changes have also been brought about as a result of decisions of

European Court of Human Rights (Padfield, 2002, 2007; Thornton, 2007; Stone, 2008).

The current powers and responsibilities of the PB are outlined in Section 239 of the CJA 2003, the Parole Board Rules 2004, and a number of Secretary of State Directions, with the PB today describing itself as:

an independent body that works with its criminal justice partners to protect the public by risk assessing prisoners to decide whether they can be safely released into the community (Parole Board Website, 2007).

Eligibility for parole is a complex area, complicated by considerable changes to sentencing law over the last 20 years, and dependent on the sentence handed down by the court (that is, determinate or indeterminate), the date of that sentence (under what CJA the sentence was passed), and the length of sentence (as specified by the courts and/or Home Secretary)<sup>70</sup>.

For prisoners serving a discretionary life sentence, PB decisions are made by single members on the papers (more commonly known as a SIFT review) and by three member panels at 'oral hearings', while those serving mandatory life and determinate sentences can expect to have their case considered on the papers by a three member panel. Panels are usually presided over by a legal member, and often for life sentence prisoners and where psychiatric or mental health issues are found to be present, a psychiatrist or a psychologist will usually be asked to sit on the panel.

Where 'the Board is satisfied that it is no longer necessary for the protection of the public that the prisoner should be confined' (C(S)A 1997, s28(6)(b)) they have the

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<sup>70</sup> For a detailed overview of PB law and practice see Arnott and Creighton, (2006); Stone, (2008); PSO 6000 Parole, Release and Recall, and PSO 4700 Lifer Manual (now called Indeterminate Sentence Manual). For changes after April 2009 see PSO 6010 Generic Parole Process.

power to direct the release of indeterminate sentence prisoners on license. The PB can also make a recommendation that a prisoner be transferred to open conditions, but they are not allowed to make recommendations regarding a number of other relevant steps towards progression.

There are several types of life sentence available to the court: mandatory, automatic, discretionary, and most recently imprisonment for public protection (IPP) sentences. Over the last twenty years the types of offence for which people can be given a life sentence has significantly expanded. Life sentence prisoners are never released until the PB has considered their case, but can expect to have their first PB review about three years before expiry of their minimum term (also commonly referred to as the tariff). This review is held on the papers only with the purpose of assessing the prisoner's suitability for open prison conditions in advance of their tariff expiry. In this vein Padfield (2002:83) notes it is 'therefore a key but invisible stage'. The second review for life sentence prisoners is usually held around the time of tariff expiry. If the PB does not recommend release at this stage the prisoner will have to wait for their next review which is usually held within the next two years.

For those serving a determinate sentence of more than four years under the CJA 1967/1991 the PB has the power to release them once they have reached their Parole Eligibility Date (PED) providing that they are not considered a risk to the public and if their sentence is less than fifteen years. The timing of the PED will depend on the CJA under which they were sentenced. 'Existing prisoners', those sentenced under the CJA 1967 and before October 1992, are eligible for parole after serving one third of their sentence, while those sentenced under the CJA 1991 become eligible for parole once they have served half of their sentence. The PED is the earliest date that the prisoner can be released, although the parole review will often take place before. If prisoners are not released at their PED they can expect to be reviewed annually up until the point

that they have completed two thirds of their sentence, their Non Parole Date (NPD). At the NPD stage, existing prisoners will be released into the community without supervision, while prisoners sentenced under the CJA 1991 are released on license, and supervised by the Probation Service until they have served three quarters of their original sentence, also known as the License Expiry Date (LED). After this point, CJA 1991 prisoners remain at risk of recall to prison until their Sentence Expiry Date (SED).

The whole basis on which people are sentenced and subsequently become eligible for parole has changed, and the PB are considered to have shifted from an advisory to a judicial role (Arnott and Creighton, 2006). Several key cases have led to increasing rights for prisoners, and the system of parole has become far more fair and transparent<sup>71</sup>. However, while the rights of prisoners may have significantly improved, the whole system has become increasingly risk averse, perhaps best reflected by the fact that key changes to the system of parole have not been accompanied by reductions in sentence length (Hood and Shute, 2000b; Padfield and Liebling, 2000a) and that recalls to prison are increasing (Padfield, 2007; Padfield and Maruna, 2006).

Recent legislation, in particular the CJA 2003, has been argued to have ‘fundamentally changed the ground rules of parole’ (Padfield, 2007:1). Two significant high profile cases and subsequent inquiries (see HMIP, 2006a, 2006b) have also forced the PB to become increasingly sensitive to risk, and sadly reflect that the PB are most often judged by their failures rather than by their successes (Huebner and Bynum, 2006; Padfield, 2007). Today, the PB has moved away from:

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<sup>71</sup> This has led to some considerable and ongoing debate about the status of the PB and whether it should be more independent from the Ministry of Justice and more appropriately constituted as a Tribunal. See the collection of papers in Padfield, 2007 for more information. See also *R(Brooke) v Parole Board* [2007] EWHC 2036 (Admin) and *R(Brooke) v Parole Board* [2008] EWCA Civ 29 and others.

considerations of rehabilitation balanced against risk, grafted on to a largely retributive 'just deserts' structure ... [to] an approach that is plainly in tune with the public protection agenda (Shute, 2007:22).

### **Previous research on the Parole Board**

Despite being central to the feasibility of the criminal justice system (Creighton, 2007), one of the most important uses of discretion in the criminal justice system (Maguire et al, 1984), and a significant decision in terms of sentence length and the numbers of people detained in prison (Tonry, 2003), 'back door' decisions like those reached by the PB are largely hidden stages of a prisoner's journey through the prison system (Huebner and Bynum, 2006; Creighton, 2007), and in comparison to other key decision-making stages in the criminal justice system such as sentencing, relatively under-researched (see Padfield, 2007; Padfield and Maruna, 2006). This is highlighted by the small amount of research concerned with the PB in England and Wales, and the fact that much of it is now dated (See for example, Barnard, 1976; Bottomley, 1973b; Hawkins, 1972, 1973, 1983a; Maguire et al, 1984; Nuttal et al, 1977; O'Leary and Glaser, 1972; and West, 1972).

The most recent, and comprehensive studies of PB decision-making in England have been carried out by Roger Hood and Stephen Shute (see 1994, 1995, 1996, 2000a and 2000b) and Nicola Padfield and Alison Liebling (see 2000a and 2000b, 2003 and Padfield, 2002). Hood and Shute's (2000b) study of PB decision-making with determinate discretionary conditional release (DCR) cases, considered how parole dossiers are compiled, how the PB assess applications in relation to Secretary of State directions, the reasons behind parole decisions, the influence of probation officer recommendations, and how risk assessment scores compare with PB decisions, while Padfield and Liebling's (2000a) study was interested to consider the operation of Discretionary Lifer Panels (DLPs), if the process is fair, the effectiveness and



consistency of DLPs, the role of panel members, how risk was assessed by DLP panels, how user-friendly DLPs were and if they could be considered to represent value for money.

A number of factors have been considered to affect the decision-making of the PB including: evidence of change (Crow, 2001; Padfield and Liebling, 2000a); completion of offending behaviour work (Hood and Shute, 2000b; Padfield, 2002; Padfield and Liebling, 2000a); insight into the offence (Padfield and Liebling, 2000a); realistic release plans (Padfield and Liebling, 2000a); behaviour in prison (Carroll et al, 1982; Conley and Zimmerman, 1982; Hood and Shute, 2000b; Huebner and Bynum, 2006; Padfield and Liebling, 2000a; Proctor and Pease, 2000); security classification (Padfield and Liebling, 2000a); nature and seriousness of the index offence (Carroll and Payne, 1977; Hood and Shute, 2000b; Huebner and Bynum, 2006; Padfield and Liebling, 2000a); length of original sentence (Morgan and Smith, 2005); psychiatric hospitalisation during sentence (Feder, 1995); attitude towards the victim; (Padfield and Liebling, 2000a); victim age (Huebner and Bynum, 2006) and offender age (Huebner and Bynum, 2006).

This indicates that a complex interplay of legal and extralegal factors are involved with parole decision-making (Huebner and Bynum, 2006) and that decisions are rarely based on one factor alone (Pitchers, 1999:124). Some of these factors may be more significant than others, and Padfield and Liebling (2000a:34) identified that panels tended to build up a cumulative picture of the prisoner from the dossier and the hearing, and that it was 'unlikely that any one factor would be decisive'. This highlights that while "the decision-making, and panels' consideration of specific risk factors, was systematic ... it wasn't standardised or validated ... and that ... they were using their 'common sense' to balance the various factors' (Padfield and Liebling, 2000a:52). A similar observation has been made in the context of MHRTs (Fennell, 1977).

## **Summary of DSPD prisoner sample and experience of Parole Board reviews**

Across the four high security DSPD units for men, sixty-six prisoners gave their consent to the study, of which thirty-five had experience of fifty-two PB reviews since admission to DSPD. The majority of participants (n=33) with eligible PB hearings were life sentence prisoners, although two determinate sentence prisoners from one service also had experience of a PB review since admission to DSPD. All of the participants had committed a violent and/or sexual offence including arson, and at the time of their last review, twelve prisoners were Category A prisoners, and twenty-three were Category B.

Prisoners were at all stages of the parole process with some undergoing their first pre-tariff expiry review, and others having had as many as ten PB reviews. Twenty-three of the thirty-five prisoners had experience of one PB review since admission to DSPD, while seven prisoners had two, and five had three. Of significant note was that no DSPD prisoner with experience of a PB review was recommended for either transfer to open conditions or release.

## **Parole Board members' experiences of Parole Board reviews with DSPD prisoners**

From the PB's conception, it was thought to be helpful if members had a good working knowledge of the criminal justice system. For this reason the CJA 1967 stipulated that members should be drawn from four categories: judges, psychiatrists, probation officers and criminologists (Shute, 2007). Members are appointed by the Home Secretary for a three year term. In March 2007 the PB had 168 members, composed of 77 independent members, 47 judicial members, 21 psychiatrist members, 8 psychologist members, and 11 probation members.

As a result of the location of the two high security prison DSPD units, and the stage in the parole system of many DSPD prisoners, not all PB members will have experience of a PB review with a DSPD prisoner. Using the records of the thirty-five consenting prisoners with a PB review since DSPD admission, forty-four members were identified as having experience of a 'DSPD review', and were invited to take part in the study. Eleven members made contact with the researcher and offered their consent to the study, giving a twenty-five percent response rate. Ten of the eleven interviews were recorded and transcribed, while detailed notes were taken and agreed with the participant for the remaining interview.

The eleven members who took part consisted of five independent members, four judicial members, one psychiatrist, and one probation member. It was unfortunate that only one psychiatrist consented to take part in an interview about their experience of DSPD reviews as nearly every other member raised the importance of having a psychiatrist or psychologist member on the PB, especially in the context of a DSPD review. Members had diverse backgrounds and experience of working with offenders, with the majority framing their previous and current roles outside of the PB as helpful to their role as a PB member. A number of members had had their contract as a PB member renewed and had spent more than three years working for the PB. A few members had retired from their full time career, and as a result, often spent greater amounts of their time on PB work.

Eight members had experience of a review for a prisoner detained on the Fens DSPD unit at HMP Whitemoor only. One member had experience of a PB review for prisoners held in the Westgate DSPD unit at HMP Frankland, and two members had been involved with reviews for prisoners from both units. Members had a range of experience of DSPD reviews with some only having sat on one, and others reporting having sat on a large number.

Other than the reports included in the dossier, information sources about DSPD for PB members varied and included information from the PB, personal research, and visits to the DSPD units. Some members reported having a wealth of information, while others recalled having been provided with far less. While members differed in their recollection of the *actual quantity and quality* of information provided to them about DSPD, they also differed in their opinion as to the *necessary quantity* of information provided in the dossier from the DSPD unit. One member observed:

Well, to be very honest you can't have too much information on situations like that (PB1, Psychiatrist member).

While others were found to hold a completely different view:

So I would slim it [the dossier] down in terms of a Category A DSPD prisoner to perhaps ten pages (PB3, Judicial member).

It was notable that most members appeared to attach significance to reports or information in the dossiers broadly similar to their expertise. There was a sense that each member 'knew their role' and directed more attention and evaluation to 'relevant' sections of the dossier accordingly. This supports previous research that has found that depending on the experience, education and beliefs of different PB members, they may look to a number of sources of data about a prisoner (O'Leary and Glaser, 1972). It was interesting that nearly every judicial member expressed dissatisfaction at the regular absence of the Sentencing Judge's remarks while the majority of members appeared to defer discussion of and judgments about treatment and to some extent risk to psychiatrist and psychologist panel members. One independent member commented:

if there's a psychologist there, that sort of almost determines it in its own way who asks what questions because the judge will chair it, the psychologist will ask you know ... the questions you would expect a psychologist to ask ... and then I'll ask any more general ones (PB2, Independent member).

Several PB members also commented on the usefulness of unit psychologists / psychiatrists attending the hearing as witnesses to give oral evidence. This was mentioned in the decision letters as well as during interview, and was described as helpful for getting more information and a better assessment of risk reduction. In the words of one PB member, having DSPD staff attend the PB review, 'brings the report to life' (PB3, Judicial member). Those members who had had the opportunity to visit the units also framed this as helpful, especially those who had been able to enter into a dialogue with staff and prisoners:

we did two days there and at some point we said 'oh it would be quite nice to walk down to the wing and just meet the officers' ... it was all done quite sort of quickly and informally ... and, actually it was very helpful (PB2, Independent member).

The participation of the prisoner was also felt to be important. This reflects Padfield and Liebling's (2000a) observation that the presence of the prisoner may have some impact on PB decision-making. Where prisoners chose not to involve themselves with the review, PB members made note of this. The decision letters and a few PB members expressed anxiety when participants, despite being visited by the Panel on the day, still chose not to attend their review, or when those who did attend, chose not to speak to the panel during the review. This highlights the importance of PB members 'knowing'

the DSPD prisoners. One member recalled a day where several PB reviews had been held with DSPD prisoners:

My recollection of one day was that everyone had their eyes covered in one way or another. One wore dark glasses, one had an eye patch ... they weren't actually making eye contact with the Panel ... that was another little cluster of very demotivated and withdrawn individuals (PB6, Independent member).

In comparison to MHRT reviews (which are discussed in the chapter that follows) it may be that the PB endure a greater struggle to know DSPD participants. This is because in contrast to MHRTs, PB reviews are often considerably shorter and staff from the DSPD units do not routinely attend. The importance attributed to speaking directly to DSPD staff and prisoners indicates that the PB valued face to face interaction and supports Krauss and Ho Lee's (2003 in Nash, 2006) view that legal decision-makers attribute greater value to the clinical assessments of 'human' experts than to actuarial tools.

### **The significance of DSPD for Parole Board decision-making**

While, generally speaking, members framed their approach to DSPD hearings as similar, if not identical, to their approach to PB reviews for other prisoners on 'normal' (high secure) location, members did however make distinctions between DSPD cases and other PB reviews. Interestingly several members gave the example of PB reviews at HMP Grendon Underwood, as being most similar to the reviews for DSPD participants. Members differed considerably in their opinions about Grendon, but several used their experience of reviews at Grendon to illustrate their concerns with DSPD.

In the main though, members suggested that DSPD reviews were the same as any other PB review. Some members claimed that DSPD reviews were notable by their shortness, and positioned the decision as an easy one on the basis that at this stage the prisoner was unlikely to be going anywhere. One member, when asked if DSPD had presented any real dilemmas for PB decision-making, commented:

They really haven't actually. As I say, you go to Whitemoor, in a sense you're not in the cast of mind where you're thinking 'shall we release this person?' (PB4, Independent member).

However, while the majority of members suggested that the decision-making task for DSPD prisoners was relatively simple, others described lengthy, detailed and inquisitorial oral panels, with witnesses and extended discussion. Some members were keen to point out that when debate surrounding the prisoner's placement existed, problems could arise:

it's a very difficult task actually ... It is difficult, especially when you don't have a clear understanding by all parties, everybody on the same side saying 'no, he's not DSPD' or 'yes he is DSPD', if all professionals involved say one thing then it's very easy because you can see the logic and the trend ... But if there is disagreement, and we have had disagreements, very serious disagreements in different prisons, which we had to defer, we had to ask addendum reports, we have to review the reports, we had to ask to disclose their assessment before it became a report, you know, the crude assessment, and we had to ask that assessment to be given to the independent psychologist, and you know, and its been quite, quite demanding I would say (PB1, Psychiatrist member).

During interview, members were found to hold different views about the label of DSPD, and the significance of personality disorder for PB decision-making. Most often members, albeit cautiously, reflected that the placement of someone in a DSPD unit suggested that they were high or very high risk:

I think if we hear that somebody has been recommended to go to the DSPD unit ... and then we find that they've been accepted, that, to me, is a confirmation of their dangerousness (PB7, Independent member).

The men that I recall at Whitemoor had committed very grave and often bizarre index offences ... involving sadism for instance or multiple acts of violence. So the impact about, that you were likely to be looking at someone who was personality disordered would be obvious wherever they were, you know, you didn't have to go to Whitemoor and know they'd be in the unit (PB6, Independent member).

These observations support previous research that has identified that labels of personality disorder (George, 1998; Rhodes, 2002) and dangerousness (Blackburn, 1996; Chin, 1998; Maguire et al, 1984) can have a significant impact on release decisions. Some PB members however were more cautious about reading too much into the label of DSPD and thought that for some prisoners placement in a DSPD unit was a positive indication:

What makes them different is the fact they're actually going through a structured programme, and a very long one, to try and do something about it (PB4, Independent member).



I think for some people, probably the majority of people, who see the benefit of going onto a unit because in recognition of their own problems ... then it's good ... And they do benefit that way ... it may be seen as there's a degree of dangerousness, but we can't judge dangerousness like that (PB8, Independent member).

Others presented those admitted to DSPD services as having certain positive characteristics. During interview the psychiatrist commented:

So the people who go to DSPD by definition have some qualities. First of all they have agreed that they have committed the offence. Secondly they have some kind of empathy towards the victim ... and thirdly they are able to cope with the demands of psychological interrogations and assessments (PB1, Psychiatrist member).

Other members were keen to point out that for the DSPD reviews they had sat on, that the prisoners could have come from anywhere and could have been anyone. Although members were confident that DSPD prisoners met the criteria, some nevertheless felt that it was arbitrary as to who was on the unit and who wasn't:

It is interesting that some of the scariest people I have ever met have not met the DSPD criteria [but] no one has ever thought about it, you know, in that context (PB7, Independent member).

And the fact is that you, in fact probably wouldn't know, indeed in some cases, whether its DSPD panel or not because we never refer to them as such ... You know they just happen to be prisoners who are on a unit (PB8, Independent member).

While members accepted that personality disorder may be seen as a risk factor, most were keen to emphasise that it was one of many, and in that respect no more significant than other factors. One member made the observation that:

I think board members find it most useful if report writers don't simply give it a sort of all embracing personality disorder label, but point out what the trigger factors and the risk situation seem to be (PB4, Independent member).

When members added other significant risk factors in addition to personality disorder, the most commonly cited was the high presence of drug and alcohol use amongst DSPD participants. The issues raised by problematic drug and alcohol use were presented as having as much if not more significance for risk and reoffending as the presence of a diagnosis of personality disorder. Members also appeared to attribute much significance to the serious nature of many of the index offences, with a few noting that the offences were often against strangers, and of a sexual nature. In this respect, there was a sense that the assessment of risk was made on the basis of static factors and what the prisoner has done/is perceived as being capable of, rather than personality disorder per se.

Generally speaking, most PB members framed the high security location of HMP Whitemoor or HMP Frankland, and the security categorisation of the prisoner as Category A or B as more relevant to their decision-making and assessments of dangerousness and risk, than the label of DSPD. One member commented:

the fact that they're on a DSPDU is not a particular issue. The real issue is, look, these guys are in Cat A prisons (PB2, Independent member).

Several members, particularly those with a judicial role, expressed some frustration at the fact that they are not permitted to comment regarding the security category of the prisoner. The significance of security classification and location for PB decision-making has previously been considered by Padfield and Liebling (2000a), who found that the 'key to release' appeared to be the security classification of the prisoner. They identified that the security classification was linked to perceptions of progress on the basis of a general expectation that prisoners would move through each of the security categories before being suitable for release (see also Padfield, 2002; Price, 2000). Padfield and Liebling (2003:106) also noted that PB panels often didn't understand the security categorisation process, and felt that it remained remarkably obscure for such a key procedure.

When asked about the significance of the treatment programme and/or the treatability of prisoners with personality disorder, most members emphasised that the PB was not there to assess what appropriate treatment might be, and/or how effective this treatment was proving to be. Indeed, like other members, one independent member observed:

We're not there to plan his treatment, we're there to decide whether he's reached the point where he can safely be either put into open conditions or released ... and it's not for us to decide what treatment is needed (PB2, Independent member).

This point was reiterated by other members, including the psychiatric member, who commented:

The Board is not there to bring medical clarification or diagnostic clarification.

The Board is looking at risk of reoffending and harm to the public. That's the aim of the Board (PB1, Psychiatrist member).

This indicates that the biggest issue for members was the level of detail about risk with most reiterating that the primary job of the PB is to assess risk to the public. This supports one of Padfield and Liebling's (2000a:x) main findings that 'the key decision to direct for release or recommend for transfer to open conditions rested on a prior decision taken, often implicitly, about risk' and that the primary concern for most PB members was whether or not they assessed the prisoner to be dangerous (Maguire et al, 1984) and likely to commit another serious crime if given parole (O'Leary and Glaser, 1972)<sup>72</sup>.

### **The outcomes and purposes of Parole Board reviews with DSPD prisoners**

In terms of outcomes it is important to note that no prisoner in the sample was recommended for either open conditions or release by the PB. This demonstrates the significance of security classification and location for PB decision-making, and that the PB is clearly focused on risk. It is likely that this concern for risk results from a concern for public protection and the possible reactions of the public and media to their decision-making (Hawkins, 1972; Coker and Martin, 1985)<sup>73</sup>. Previous research with the PB that has suggested that:

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<sup>72</sup> This decision about risk was also thought to rest 'upon a myriad of decisions taken about the apparent facts of the case', with panels often found to spend more time discussing 'extra-curricular' issues, rather than discussing directions and/or risk (Padfield and Liebling, 2000a:33).

<sup>73</sup> According to Cohen and Taylor (1972) prisoners are aware that public opinion feeds into the parole process.

The 'risk decision' is made overtly on the basis of the documentation on each case contained in the parole dossier, together, no doubt, with some sort of unwritten, and probably unspoken, conjecture of how public opinion might view the decision if it knew the facts (Coker and Martin, 1985:47).

While risk and public protection are important concerns for PB decision-making, in practice, several other purposes are tied up with the system of parole. Barnard (1976) identifies five main objectives of parole: rehabilitation, reward, management tool, cost saving and public protection. This demonstrates that parole is structured by rehabilitative, institutional, political and economic concerns (Morgan and Smith, 2005; see also Simon, 1993).

Hawkins (1972) suggests three inter-related effects of the parole decision: the motivation of prisoner behaviour; maintenance of institutional morale; and the maintenance of population equilibrium. This indicates that in the total institution, questions of release are built into the rewards system (Goffman, 1961:53), and that parole is used as an incentive and mechanism for maintaining institutional discipline (Appleton and Grover, 2007; Barnard, 1976; Hawkins, 1973; Maguire et al, 1984; Proctor and Pease, 2000). Parole also has the dual purpose of surveillance and help (Irwin, 1970). Importantly, Hawkins (1983a) reminds us that like other decisions taken in the criminal justice system, decisions made by the PB are symbolic, and involve moral judgments. In his words:

In making judgments about release or restraint, a Parole Board is engaged in the appearance of condoning or condemning criminal behaviour; it is making statements about good and evil, desert and punishment, to the prisoner, the institution, and the wider community. The parole decision, in short, is symbolically significant (Hawkins, 1983a:102).

Padfield and Liebling (2000a) found that while members agreed that the main aim of the hearing was to decide if it was safe to release someone or not, other purposes for the review were still found. Despite the fact that PBs are constrained by their formal terms of reference:

they often recommended other progressive moves ... [and] ... often used the decision letter to fulfill many functions including relaying a message to the Prison Service (Padfield and Liebling, 2000a:xi).

These recommendations tried to encourage the Prison Service to take a particular course of action, but panels were careful not to word such recommendations too strongly, and would often note that such recommendations were beyond their remit (Padfield, 2002:97). Some members saw the hearing as being able to 'check' on and independently review the management and treatment of lifers, while others saw the review as able to have a steering effect, in the sense that it encouraged assessments of progress to be made in cases where release was an unlikely outcome. At the very least, Padfield and Liebling (2000a:117) found that panels were keen 'to reinforce positive recommendations made in reports ... [and to] ... 'do good' where good could be done'<sup>74</sup>.

As reflected in the discussion of the significance of the high security location and classification of DSPD prisoners, most members were keen to assert the importance of prisoners undergoing a 'journey' in prison through different levels of security, on the

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<sup>74</sup> Padfield and Liebling (2000a) found that there was some debate however amongst members about the appropriate remit of the PB, with some arguing that the Board should not encroach on the work of the Prison Service, and others arguing strongly for an enhanced ability to make recommendations in order to help prisoners move through the system. They suggested that these recommendations should create 'legitimate expectations' for the prisoner unless rejected by the Home Secretary, however they also found that in two thirds of cases, the recommendations made by the Panel were rejected.

basis that this would allow for participants to be 'tested' at different stages of their sentence. One member commented:

What I have realised is that long term prisoners, and DSPD prisoners are inevitably long term prisoners, generally serving a life sentence ... undertake a journey whilst they're in prison. And their journey is high security initially, until the prison is satisfied, that they're not a high security risk. They then go to medium security ... and they then go to low security. I've realised since I joined the Parole Board that releasing a prisoner from high security into the community ... is not a good idea. Because, he just hasn't got any of the skills ... you can't just sort of open the door for him and push him out at age forty-two and expect him to behave normally. He's got to go through a journey (PB2, Independent member).

In the main, the PB decision letters to DSPD prisoners were fairly similar in their structure and focus, as required by the PB guidance. PB decision letters are important documents for a prisoner's career, demonstrated by their inclusion or summary in subsequent dossiers. Unsurprisingly then, the decision letters were structured by a concern with different moments of a prisoners journey. First, who they were at the time of the index offence and sentencing stage, and then who the prisoners have become within the institution - what they have done, where they have been and how they have changed. This highlights that 'an important element of the parole system still centres around whether the prisoner has demonstrated change or willingness to change' (Crow, 2001:26).

All but one decision letter began with an outline of the index offence, and subsequent sentence handed down by the courts. The majority then go on to discuss the previous offending of the prisoner and where relevant their involvement with drugs and alcohol.

Decision letters varied in their focus on the prisoner's journey prior to DSPD, although several PB members raised its importance in interview. In the decision letters, many panels focused on the progress that had been made since the last review, and often did not describe how the prisoner had behaved earlier in his sentence. For those with particularly turbulent institutional careers, reference was often made to their earlier behaviour, indicating that the PB will not condone any wrongdoing in the institution.

Analysis of the interviews suggested that members clearly distinguished between reviews in lower security concerned with open conditions or release, and reviews in high security concerned with reviewing the progress made and outstanding areas of work. This distinction between, in the words of one participant, 'release' and 'review' PB hearings (PB3, Judicial member), led to PB reviews taking a different focus, a point previously identified by Padfield and Liebling (2000a). The implications of this for PB reviews with DSPD participants was summarised by one member who commented:

In terms of the distinction everybody knows that the prisoner is going nowhere and therefore it's a review hearing, pure and simple to identify areas of concern to the prisoner or his legal rep to address ... but in terms of the main function of the Parole Board which is release or recommendation for open, it's not going to happen (PB3, Judicial member).

This highlights that a 'prisoner must successfully negotiate a variety of Prison Service hurdles (categorisation, allocation, offending behaviour courses and so on) as a prerequisite to release' and that in practice, the power of the PB to direct release is seriously constrained (Padfield, 2002:99; Padfield and Liebling, 2000a:xiv). This also indicates that the key issue for prisoners held in high security prisons is 'more likely to be whether there was anything specific that the panel could do to help 'move the



prisoner on' (Padfield and Liebling, 2000a:63). This was highlighted during interview with one independent member:

Our approach has usually been what progress has been made by now. What are the risk factors that have been identified and how are they being dealt with? ... and then ... not normally a recommendation, but sometimes an observation about what needs, what seems to be the next link in the chain (PB4, Independent member).

The distinction between release and review hearings was reflected in the decision letters making little use of home probation officer reports and making little reference to the prisoner's situation on the outside. The prisoner's situation on the outside was only mentioned in three decision letters (for two determinate prisoners and one life sentence prisoner). This indicates that many PB members considered DSPD participants to be in the early stages of their sentence and treatment, and that there was still a long way to go. This also demonstrates the importance of time in the governance and decision-making about long term prisoners (Cohen and Taylor, 1972) and that assessments about whether the prisoner had served 'enough time' have structured PB decisions (Hawkins, 1972, 1983a, 1983b; Maguire et al, 1984). While PB members were keen to argue that they were as thorough with high security reviews as they would be with reviews in lower security, and that the process was the same, there was nevertheless the sense that members knew the outcome in advance of the review. This was particularly evident in one review where the panel refused to adjourn for independent reports to be collated, on the basis that it would make no difference to the outcome.

The reasons given by the PB suggested that they were keen to present their decisions in line with the recommendations of the report writers. A common phrase in the reasons given to DSPD prisoners was 'no report writer supports release'. In addition,

the decision letters often noted when either the prisoners representative and/or the prisoner themselves, also agreed that release or a recommendation for open prison was not appropriate at this stage. In the main, most prisoners and their legal representatives appeared to accept that at this stage a progressive move was unlikely, and instead requested that the progress made be acknowledged by the PB. When the prisoner is reported to have agreed with the PB that this was not an appropriate stage for open conditions or release, they appeared to be given some credit for this. PB members described themselves as feeling reassured if prisoners took a 'realistic' view to the process. This indicates that the PB, by presenting their decision as in line with the report writers, legal representative and/or the prisoner, seek to legitimise and evidence their decision. It also suggests that members are mindful of the need to maintain the engagement of DSPD prisoners, and present the outcome positively to the prisoner.

Analysis of the decision letters found that most made reference to the fact that the prisoner was residing on a DSPD unit, and often made reference to previous hospitalisation and/or a previous diagnosis of personality disorder. While DSPD was rarely listed as a risk factor in itself, on one occasion for a participant who was recorded as having struggled to come to terms with the diagnosis, the PB decision letter actually lists DSPD as one of the risk factors. This mentioning of past and current diagnoses of personality disorder and 'DSPD' suggests that the PB seeks to reinforce that DSPD is an appropriate placement to the prisoner.

It was of note that where it arose, the decision letters often attributed the lack of risk reduction or completion of offending behaviour courses to regular moves within the prison estate, and where the decision letters confirmed that there had been reduction of risk, this was most often attributed to the completion of offending behaviour work.

This is likely to reinforce the importance of offending behaviour programmes and the need to limit transfers around the prison estate to the prisoner.

Only a few prisoners were described as having not improved their attitude since arrival in DSPD, and this was noted in the decision letters. Nearly every participant was given credit for their involvement in the DSPD programme. However, this was usually followed by a comment regarding how much outstanding work remained. Many outcome letters made reference to the fact that DSPD was a long programme and that participants were in the early stages. It was usually implied that this outstanding work was DSPD related. Indeed, one panel, like many, commented:

while you should be given full credit for the steps which you have taken to engage with a demanding programme, you have substantial work still to do on the DSPD programme (2032, 3(1) PB decision).

Often the decision letters did not make explicit recommendations to the prisoner, but there was an implicit sense that their placement on DSPD was appropriate and that it was in the prisoners interests to continue with the programme. It was apparent that the PB letters tried to encourage and/or maintain the motivation of the prisoner to engage with DSPD:

Not only are you making progress on the DSPD programme, but you have the capacity to change and to be a pro-social member of the group (2056, 4(3) PB decision).

The panel hope that by the time of your next review the progress you have made will have been maintained (2026, 5(2) PB decision).

While nearly all participants were credited for an improvement in motivation since admission to DSPD, subtle differences between prisoners could be found. This reveals the ability of the PB to determine status and the important and symbolic nature of PB decision-making (Hawkins, 1983a). On two occasions, the decision letters made reference to a prisoner having become a 'different person'. One of the decision letters reports:

you are no longer confrontational. This is a far cry from the person you once were ... you have constructed a new identity, and are keen to understand why in the past you have been so destructive (2052, 2(2) PB decision).

In contrast, on a few occasions, a sense of scepticism can be discerned from the PB decision letters with the use of terms like 'you apparently...', 'you are said to be...' or 'you submitted...'. This suggests that some DSPD participants were perceived by the PB as having failed to change from who they were at the time of committing their index offence. This demonstrates that PB members make assessments of how genuine the prisoner's approach to treatment and parole is. Scepticism was also shown in other ways. Other panels made the observations that:

He is said to have settled well on the [DSPD] unit and since arriving he has been adjudication free, probably because of the high security levels (4023, 6(1) PB decision).

The Board noted you have changed your name again to [name], and that this might indicate a wish to avoid responsibility (2020, 8(1) PB decision).

PB members have also been found to make assessments about offender blameworthiness (Hawkins, 1983a) indicating that some parole officials see themselves

as 'resentencers', responsible for reevaluating the evidence in the original case' (Metchik, 1988 in Huebner and Bynum, 2006). Assessments of blameworthiness were occasionally evident in the PB decision letters. For one prisoner who had been diagnosed with temporal lobe epilepsy since sentencing, and could have offered a defence of not guilty by reason of insanity, the PB still felt compelled to comment:

Such a diagnosis does not explain the presence of a knife (4025, 1(1) PB decision).

While scepticism could be found, the PB most often appeared to strive for a positive outlook, and the decision letters worked hard to strike a balance between negative and positive comments. This indicates that PBs must maintain a balance between the reward and sanctioning of behaviour (Hawkins, 1972). While no panel felt able to recommend a progressive move, the decision letters often made a point of noting when the prisoner was doing well in education, work, or extra-curricular activities. For one prisoner, the PB decision letter observed:

the Panel noted that you were wearing a striking reversible coat and shirt, which you had designed. You have significant creativity, which you are putting to good use (2056, 4(3) PB decision).

Often those with a particularly problematic history during their sentence were given credit for smaller achievements. One participant was given credit for 'volunteering' for DSPD which the panel noted was 'progress in itself' (2046, PB decision), another was 'to be given credit for finally accepting a place' (4003, PB decision), while another was commended for having re-engaged with DSPD (2035, PB decision).

In addition to using the review to allocate credit to prisoners for their involvement with DSPD, and to encourage their continuing motivation with the programme, the PB also appeared to use the review for other purposes. Occasionally the PB decision letters for DSPD participants were found to adopt an advisory role to the prisoner. On one occasion when it was apparent that the prisoner wanted to be transferred out of the DSPD unit to another prison the panel noted:

you confirmed that this is indeed your wish, and it was impelled by your subjective reaction to the nature of the therapeutic work being undertaken within the DSPD unit, and the very painful emotions which this was generating for you ... while the panel is obviously sympathetic to your position ... its concern is primarily whether, should you be transferred to another establishment ... the likelihood is that your eventual re-categorisation would have been set back by a significant period ... you will no doubt wish to review the wisdom of your proposal with your solicitor (2035, 3(1) PB decision).

This quotation highlights that decision letters sometimes tried to empathise with prisoners. This suggests that a PB review has the potential to have a pastoral or therapeutic effect on the prisoner, in that it has the capacity to encourage participants to (re-) engage in the DSPD treatment programme. It appeared that the PB review was used not only to encourage engagement, but also to allow prisoners an opportunity to 'have their say':

the Parole Board hearing was used by staff I think to encourage inmates to re-engage but it also meant that the inmate if he wanted to could air a grievance about something which unfortunately wasn't likely to be relevant to the Parole Board's decision ... So it could have a sort of slightly therapeutic / stroke

management aspect to it which would distinguish it from other sort of Parole Board hearings (PB6, Independent member).

While the PB decision letters sometimes extended understanding to the prisoner it was of note that they tried to avoid raising their hopes, and also allocated much responsibility to the prisoner for the management of their situation. On a few occasions prisoners had presented as being frustrated at the length of time taken waiting for assessment and/or progression through DSPD and the wider prison system. The PB's response to this was often to turn it back onto the prisoner, responsibilising them for their reaction to what the PB acknowledged may be a frustrating situation. In one decision letter the PB made the observation that:

While his frustration that comparatively little has been gained since his 1<sup>st</sup> review by the Board may be understandable, he will need to avoid becoming self-defeatingly negative in outlook and behaviour (4006, 2(1) PB decision).

In the main, concerns about the DSPD programme were not raised in the decision letters. However, there were occasions when the decision letters were found to send a message to the unit and/or wider Prison Service. This was rare and often done subtly, indicating that the PB try to make no judgment of the programme on paper. The following quotation however from a decision letter demonstrates how the PB may attempt to persuade the Prison Service:

you have been waiting for a very long time to be assessed for the treatment available at Frankland. You understandably hope that the panel can achieve some priority for your assessment on the DSPD programme. The panel heard evidence from the chartered forensic psychologist ... about the prioritisation policy. We cannot direct that you are given any specific priority but we do

express concern that you have been waiting for a very long time and have still not been assessed. There is a risk ... that you may lose your motivation and commitment with the passage of time (4018, 5(1) PB decision).

For another participant in the later stages of DSPD treatment, the panel expressed concern about the lack of information about risk reduction and about the perceived lack of liaison between the DSPD units and the wider Prison Service. In their words:

the panel had no information provided to it about the level of risk you presented at the beginning of your time on the Unit (static risk) and the extent to which risk had been reduced if any (dynamic risk). There appeared to be little liaison between the Unit and the main stream prison system ... The panel considers that if your next review is to be a meaningful exercise, any future panel must be provided with information to enable them to conclude whether risk has been reduced and the extent of that reduction, and there must be agreement between the unit and the main stream prison system as to how and in what timescale progressive moves can be effective. It may be that you will need to instruct an independent psychologist to assist in this process (2055, 3(3) PB decision).

This statement suggests that the PB are interested with assessing change, and that the review may be used to persuade the Prison Service to follow a particular course of action. This statement also indicates that the PB aim to encourage the maintenance of prisoner motivation by taking note of their concerns, emphasising that more information should be available at the next review, and advising the prisoner that they may wish to instruct an independent expert to review their case.



A small number of other prisoners received decision letters that mentioned that key DSPD reports should be available at the time of the next review. This highlights previous research that has shown that rather than defer cases because of the lack of clinical information, it is more common for the PB to recommend inclusion of a psychiatric report at the time of the next review (Pitchers, 1999:115). A small number of other decision letters subtly raised the issue of information about risk, progression, timescales, and available step down services, although this was most often done by quoting from the reports that things should be clearer by the next review. Indeed one decision letter stated:

The Panel noted the observation of [the psychiatrist] that 'at the present time there is no established progression route for prisoners completing DSPD treatment ... plans to develop progression pathways are under way and are likely to be much clearer at the time of your next review' (2056, 4(3) PB decision).

### **Anxieties about the journeys of DSPD prisoners**

While the staff in DSPD were perceived by PB members as hardworking, reflective and determined to assure positive outcomes with a difficult group, outside of this, much anxiety and scepticism appears to remain. While PB outcomes rarely questioned the unit, and most often reinforced the need for the prisoner to engage, privately some PB members had concerns. While members were keen to remind me that the role of the PB was not to pass judgment on the treatment programme, members, implicitly at least, did hold views as to the efficacy of the treatment programme offered by the DSPD units. The majority of members expressed some doubt and varying degrees of scepticism about the treatability of those within the DSPD units. One member commented:

Well as far as I know ... it's not proven that whatever 'treatment' ... [given] to people in these units is going to work, because conventional wisdom ... is that you can't treat personality disorder and therefore I'm still a little bit perplexed about the whole thing, but you know, I'm not a psychologist or a psychiatrist, so far be it for me (PB7, Independent member).

Generally speaking, scepticism about the treatability of DSPD prisoners was not directed towards one source but instead focused on the participant's ability to change, the ability of the unit and current understanding to evoke change, and concerns that the political aims of the DSPD programme were unclear or unfounded. While members tended to be confident that prisoners on the unit met the criteria, some had some concerns about the time involved with assessment and treatment:

And then, once they get onto the unit, you find that they'll get through the first stage, and ... this sounds terribly cynical but it's just the way it is, they'll do one programme, they complete that, then they'll be assessed, then they'll find a whole range of programmes set out ahead of people, so often ... prisoners will want to get off the unit to get back onto normal locations so they can take up a normal...a more common range or programmes ... which may have the same effect at the end of the day. And I do feel sometimes that the psychologists, forgive me ... [but] nonetheless they get into almost a revolving door of programming (PB8, Independent member).

This quotation demonstrates that there is some anxiety amongst members about the length, amount and nature of the treatment programmes being offered by DSPD, and uncertainty about whether they are any better than 'normal', 'traditional' or 'accredited' offending behaviour programmes. In this sense, DSPD is considered to disrupt PB member's conception of the normal and appropriate journeys that long term prisoners

should undergo before being considered for release. Some scepticism is also directed towards the role of psychologists in the management of offenders, a point made in terms of risk assessment by another member:

one sometimes feels that ... particularly in defense of serious offenders, and this may be highlighted in the case of the DSPD unit, that psychologists and to a lesser extent psychiatrists have found the Holy Grail which is that by ticking enough boxes and enough forms they will eventually be able to come to an absolutely accurate assessment of risk, and of course it's absolute nonsense, and it's in pursuit of that that there are endless delays where actually meeting a prisoner face to face on the panel there's a chair, psychiatrist, and always a psychiatrist in DSPD case, and a layman, and you get a much better idea about how dangerous this guy is than ticking boxes I'm afraid (PB5, Judicial member).

Interestingly, this member privileges common sense, psychiatrists and the PB for making assessments of risk, and there is a sense that this member feels that you do not need to be an expert (with expert knowledge and risk assessment tools) to work this out. This also highlights that several members were dissatisfied with the general state of risk assessments, in both DSPD and the wider Prison Service. Another member suggested that the information provided by a DSPD dossier was 'data rich, information poor', and advised that what the PB needed was the 'Enid Blyton guide to risk' rather than a detailed history of risk assessment tools (PB10, Judicial member). This member also argued that when the units provided risk assessment scores it would be helpful if they were also given a brief summary of what the score means. Other members appeared dissatisfied with being given scores, but equally dissatisfied with lengthy clinical reports detailing the numerous risk factors to be found.

Analysis of the dossiers and interviews with PB members revealed that most often the dossiers supplied by the DSPD unit to PB members were very detailed in terms of the history of participants, and in the identification of risk factors, while discussion of progress in treatment and risk reduction was less specific. One member noted that:

they do identify very clearly the risk that is being assessed and details of the index offence and the relevant previous history, if there has been any work done in prison ... [but] ... they don't provide any information of the actual work that's being done other than in very general terms (PB9, Judicial member).

Similarly, another member made the observation in regard to the psychiatric reports that the:

reports are always in a similar format, namely the prisoner is half way through the programme, we don't really know if it's gonna work or not, we think it is, we hope but it's far too early to say and it's a suck it or see sort of report (PB3, Judicial member).

While in many respects this is understandable because prisoners are still in the early stages of the treatment programme, and the units are understandably cautious about making any promises about the success of the programme, yet it was apparent that this was an emerging problem for PB decision-making. While members identified that information about changes in risk was often unavailable, they differed in their view about the implications of the absence of this information. Some accepted that it was early days for the unit and therefore impossible to make accurate judgments about risk, while others argued that risk reduction needed more attention in the reports. One member noted:

we need very clear, because of the nature of these particular offenders, very clear evidence about whether or not there's been any reduction in risk, and it is almost invariably the case when dealing with a DSPD prisoner that the panel never gets that information (PB5, Judicial member).

One panel agreed with the unit, and identified that at this stage it was difficult to assess risk reduction. The decision letter observed:

It will not be feasible to assess your risk until you have completed the programme; and in the interim you are not considered suitable for release or open conditions (2056, 4(3) PB decision).

One member when asked about the adequacy of information provided to them about risk suggested that the information supplied by the DSPD units was at this stage unproblematic:

So I would say, no I mean it was probably adequate for the decision that we had to make about whether the inmate could be released or not but the more interesting stuff about the aims and what actually was taking place wasn't provided in written forms (PB6, Independent member).

This indicates that while the PB may find it relatively easy to make decisions about prisoners who are still detained in a high security DSPD unit and have yet to complete treatment, future PB decision-making with DSPD prisoners once they have completed treatment, may be more difficult. Some members pointed to the difficulties in assessing risk and in identifying if DSPD treatment has worked. One member commented:

I'd liked to have had more information on what they think the outcome is, what they think they can expect to achieve, and how anyone looking at the prisoner ... can know whether it's been achieved. I mean other than he's not raping anybody else, how are you going to know it's worked? (PB7, Independent member).

Most members offered their thoughts about the future although a few did not, on the basis that at this stage it was impossible to do so. While members accepted that it was still early days, the majority expressed some anxiety about the future implications of placement in a DSPD unit for the progression of DSPD prisoners and the decision-making of the PB. Members were unclear where the programme would lead, and many were not overly optimistic about the likely progression of DSPD prisoners through the prison system.

PB members expressed concern as to how these DSPD prisoners could progress/transfer back to the mainstream Prison Service, for a variety of reasons. First, DSPD prisoners were framed as having become used to, and by implication dependent on, individual therapy and high staffing levels; provisions that were framed as unlikely outside of DSPD services. This highlights some of the scepticism regarding change discussed earlier in the chapter and that PB members often attributed stability and/or any positive change in behaviour to the high levels of staffing rather than genuine change on behalf of the prisoner.

Members were anxious about the relationship of DSPD with the wider criminal justice system. Many members believed that it would be difficult to progress DSPD prisoners to lower security prisons because they did not understand the work of the DSPD units and would not want ex-DSPD prisoners. This followed from concerns about the

potential stigma that would follow from the label of DSPD. One member recalled a conversation with a senior officer on the unit:

What he said to us ... was that other prisons are quite reluctant to take people from the DSPDU ... simply because you know, it starts *dangerous* and severe personality disorder unit, you know, and if you're the receiving officer at HMP wherever and you see dangerous and severe personality disorder, do you want the guy? (PB2, Independent member).

Most raised the difficulties of resources. Some PB members also seemed anxious about the implications of the DSPD programme for the wider Prison Service, raising concerns that the DSPD units would become silted up. One judicial member commented:

The belief which I think runs contrary to the evidence that they can actually effect some sort of permanent change ... it's having the affect of holding people back rather than allowing them to be tested as they gradually progress through the conditions of security ... [I'm] just nervous frankly about the effect that it's having on the prison population as a whole (PB5, Judicial member).

Anxieties about the implications of DSPD for prisoners elsewhere in the system were also raised by a few members who recalled PB reviews in lower category prisons, when they had come across a referral to a DSPD unit. Those who recalled experience of lower security prisoners being referred to DSPD had grave reservations about the practice. One member commented:

The other thing that puzzles me to the point of concerning me is how ... and this has happened two or three times recently, somebody can be in open

conditions, or indeed applying for open conditions and have had no particular recent example of, ...poor behaviour, then out of the blue comes a psychologist in another prison suggesting that he be assessed for the DSPD. Now, that automatically you know, throws up a sort of great big sort of question mark, but I think to myself, hold on, how can somebody have got this far through a prison sentence and this come up now for the first time? So I fear a little that people are being tarred with this brush just by virtue of anybody suggesting that they should be assessed for it (PB7, Independent member).

Members were also concerned that current DSPD prisoners may be required to repeat similar offending behaviour programmes. The following observation from a Judicial member clearly demonstrates this, and suggests that DSPD disrupts the traditional ideas that PB members hold about what a normal journey through the Prison Service should look like:

I do have issues about ... it not being identified what work is being done. And my understanding that what work is being done is not anything in the nature of accredited programmes of the normal kind ... as you'll be very much aware, the whole risk assessment process is ... intended to be very structured and is very much linked to offending behaviour work. And so for the very violent and particularly the sexually violent, the invariable pattern is for a variety of the SOTP family of courses, starting with the SOTP course in many cases actually possibly even going round that course twice ... the belief is that ordinarily the courses that should be undertaken should be accredited ... I don't think anyone's fully worked out the extent to which any of those who once they leave the DSPDs will then be expected to rejoin what might be described as the more conventional offending behaviour path. I mean will they go back and be expected to do the SOTP courses? Or is the work that they're doing in the unit



intended to as it were replace? Then, when they leave the unit, will the assessment of the risk of those prisoners ... be acceptable to the risk of assessment process? Because there won't be any yardsticks against which to measure it (PB9, Judicial member).

Several members drew on therapeutic communities to make their point regarding DSPD reviews. These views are particularly relevant because Grendon has been identified as a step down facility for DSPD prisoners. Like much else, PB members held differing views about the value of therapeutic communities. Some felt that specialised placements were positive, but many were unclear about what they actually do, and the extent to which they may reduce risk. One member observed:

Many of the problems that I've been raising [about DSPD] are probably similar to problems that in reality Grendon have had for some years. Namely the reports that come out of Grendon are not of a high quality ... They use their own treatment. And so sometimes you could spend three or four years in therapy ... of course therapy is not treatment as such ... But you can spend a long time in therapy in Grendon and come out with a glowing report and then find yourself in a conventional training prison and be assessed as requiring to do a lot of the offending behaviour programmes that you undoubtedly felt were no longer necessary as a result of all the therapy you'd had ... And the people who work in Grendon are always regarded as being particularly supercilious and reluctant to umm give full details of what, what's been happening. So that's a sort of parallel (PB9, Judicial member).

## **Conclusions**

It is still early days for the DSPD units, and because of this, PB members all appeared keen to reserve judgment about the implications of DSPD services for PB decision-

making. While many were anxious about the progression of prisoners within DSPD services, many accepted and reiterated that this was a relatively new service and that participants were still in the early stages of treatment. On this basis many accepted that the details they require to make decisions about risk at this stage remained unknown.

It is important to note that members differed considerably in their view as to the appropriate amount and type of information needed to make decisions. While PB members may be provided with adequate information about the prisoner, less information was provided about any change that may have taken place, and what exactly goes on within the unit. This demonstrates that anxieties can be generated by new strategies of control, and that the DSPD units are keen not to promise change too soon. Risk was found to be a very important consideration for PB members, however because of the high security location of DSPD units some members suggested that the quantity and quality of information did not pose them too many difficulties in terms of decision-making because prisoners were unlikely to be recommended for either open conditions or release. Members were however anxious that they would need more detailed information on risk and any changes to it as prisoners came towards the end of the DSPD treatment programme, and had moved to lower security locations. This reflects the distinction made between 'release' and 'review' PB reviews, and the importance of information about risk reduction and progression for the PB.

PB members were quick to point out that their primary concern and statutory authority related to the assessment of risk to the public, and that as PB members they were not there to assess the suitability and/or merits of the treatment programme. Members were nevertheless sceptical as to the likelihood of positive outcomes as a result of treatment on a DSPD unit. Despite this, PB panels most often used the review to encourage DSPD prisoners to maintain their engagement. Analysis of the PB decision

letters showed that on paper, the PB were keen to encourage continuation with the DSPD programme. While no decision letter made recommendations for open prison or release, the PB still made informal recommendations and observations to the prisoner. These most often centered around commending the participant for their progress so far, and encouraging them to stick with it and keep going. For those who had had particularly turbulent prison careers and/or had struggled to come to terms with their DSPD placement, much credit was given for their new outlook. This indicates that a PB review for a DSPD prisoner provides the opportunity for the participant to have their progress formally recorded.

While the outcome was the same for all DSPD participants, it was apparent that some distinction between prisoners was made by the PB. Members held different views about the impact of DSPD on PB decision-making with some members regarding the placement of a prisoner in a DSPD unit to be 'confirmation of their dangerousness', others keen to point out that they considered DSPD prisoners to have the ability to cope with psychological treatment, and others presenting DSPD participants as no different from other long term prisoners. This highlights that criminal justice staff and external decision-makers like the PB make assumptions about the type of people that particular programmes like DSPD are set up to cater for.

Occasionally the decision letters offered advice and/or encouraged prisoners to reconsider their approach. While some decision letters extended empathy to the prisoner about their situation, they were also keen not to make any promises, and to make the prisoner responsible for their reaction to what they 'understood' may be a difficult situation.

On paper the PB usually reinforced the legitimacy of the DSPD programme, and it was rare that the decision letters were considered to send a message to the DSPD unit.

This suggests that the PB strive to be supportive to both the DSPD units and the prisoners. Most often Panels were considered to present as a neutral observer (only looking at prisoner) or as an ally of the unit (to help reinforce/encourage engagement). On occasions panels were also found to adopt more of an auditor (questioning, degree of scepticism) or critical (political) view. The concerns most often raised by PB panels centered around the need for more information about the reduction in risk and level of change, and/or information about timescales for progression.

Members were keen to demonstrate the importance of prisoners undergoing a 'journey' through the Prison Service and the different security categories in order for their risk to be 'tested' along the way. Within this, PB members were keen to reiterate that the high security location and/or classification of DSPD participants was more relevant to their decision-making than the label of DSPD. In addition members pointed out that while personality disorder may be seen as a risk factor, it was one of many, and in that respect no more significant.

While the majority of members clearly felt that it was important for prisoners to undergo a journey through the Prison Service, DSPD is considered to disrupt their ideas of what this journey should look like. During interview members were sceptical that the programme would work, unsure of its relationship to other traditional offending behaviour programmes, and unclear as to where DSPD fits with the wider criminal justice system. PB members were also anxious about the length and time involved with DSPD assessment and treatment, indicating that time is an important theme with DSPD and PB reviews. While PB members are no doubt sceptical about the ability of other offending behaviour programmes to bring about change, it appears that they are more confident with these traditional and known approaches to offending behaviour. This suggests that the fact that much remains unknown about DSPD raises anxieties for external decision-makers like the PB. These anxieties have implications not only for

the future of DSPD prisoners, but also for recent proposals to introduce 'hybrid' prisons (Cabinet Office, 2007).

## 8. DSPD and Mental Health Review Tribunal decision-making

*The potential benefits of treatment do enable Tribunals to accommodate decisions  
which result in offender-patients remaining in confinement as reluctant clients  
(Peay, 1989:137).*

### Introduction

This chapter, like the one that precedes it, explores what sense external decision-makers make of the DSPD programme. Drawing from the MHRT outcomes and interviews with MHRT members, the analysis considers the significance of DSPD for MHRT decision-making. In contrast to the experience of prisoners with PB reviews, DSPD patients had a range of experiences with the MHRT ranging from absolute discharge to the community, recommendation for return to prison, recommendation for transfer to lower security mental health facilities, and reclassification of their mental disorder. The majority however, like the prisoner sample, received no formal recommendation for either a transfer or discharge, although the MHRT reviews were still considered to serve other purposes. Privately, and similarly to PB members, some MHRT members were anxious about the future institutional journeys of DSPD patients, and in particular, had grave reservations about the practice of transferring prisoners at a late stage of their prison sentence to hospital.

### The Mental Health Review Tribunal

MHRTs are independent judicial reviews concerned with the legitimacy of detention under mental health legislation. Established under the Mental Health Act of 1959 following the recommendation of the Percy Commission in 1957, their role and purpose

was amended and further extended by the Mental Health Act 1983<sup>75</sup>. The law governing MHRT's is outlined in Part V (Section 65-79) of the MHA 1983 (as amended by the Mental Health Act 1983 (Remedial) Order 2001) and separate Mental Health Review Tribunal Rules 1983 (as amended in 1996). The functioning of MHRTs has also been amended by case law (McMurran et al, 2009) and MHRT panels must also consider non-statutory guidance issued by the Ministry of Justice (MoJ, 2007a)<sup>76</sup>. There is one MHRT in each NHS Regional Health Authority in England and one in Wales. According to the MHRT Service website (and prior to amendments under the MHA 2007) their:

main purpose is to review the cases of patients detained under the Mental Health Act and to direct the discharge of any patients where the statutory criteria for discharge have been satisfied (MHRT Website, 2007).

Since the MHA 1983 applications to the MHRT have risen (Blumenthal and Wessely, 1994), and they now deal with approximately 24,000 applications and 13,000 hearings each year (Snowden and Ashim, 2008:202). Eligibility for a MHRT varies according to the section under which a patient is detained, but generally, patients are entitled to apply for a MHRT within the first six months of their detention and once every year thereafter. If no application has been made by a patient (or a representative of the patient) within three years, the Secretary of State is obliged to call for a review.

Each MHRT panel must consist of a legal member (who must preside, and in the case of restricted patients is required to be a Circuit Judge or Recorder), a medical member (most often a psychiatrist, although not always forensic) and a lay member (an

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<sup>75</sup> The law governing MHRTs has been subsequently amended by the MHA 2007 amendments to the MHA 1983 which came in force in November 2008. The law described in this chapter relates to the provisions before this new legislation came into effect.

<sup>76</sup> Prior to the creation of the Ministry of Justice in May 2007 this guidance was issued by the Home Office (see Home Office 2004).

individual who is neither legally nor medically trained, but still deemed to have an awareness of mental health issues). Members are appointed by the Lord Chancellor, although in the case of medical members the Secretary of State for Health is also consulted. 'Each member of the tribunal is entitled to an equal voice on questions of law, procedure and substance' (MHRT Website, 2007) and where there is disagreement, the majority view is taken to be the decision.

MHRTs can be thought of in three stages; pre-hearing, actual hearing, and deliberation post hearing. Following application for a MHRT, the Mental Health Tribunal Rules 1983 (Schedule 1, Part B) require that up-to-date medical and social circumstances reports are prepared for the tribunal. Reports must also be provided by the responsible local authority, and in the case of restricted patients, by the Secretary of State. Other reports are often submitted from independent psychiatrists (hereafter IP) and psychologists.

Along with the three member panel of the MHRT, the Responsible Medical Officer (hereafter RMO), a psychiatrist, an Approved Social Worker (hereafter ASW) and the patient and their representative will usually attend the hearing. Other witnesses may be called including IPs. After the hearing, which is usually held in private in the hospital in which the patient is detained, the MHRT will deliberate in private about its decision. Its decision and reasons for it must then be provided to all parties within seven working days.

The substantive powers of MHRTs are outlined in s72-75 of the MHA 1983<sup>77</sup>, with the criteria for discharge largely mirroring the criteria for admission to treatment (Bartlett and Sandland, 2007). The main function of the MHRT is 'to decide if the essential

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<sup>77</sup> See MHA 1983 (prior to MHA 2007 amendments). For a detailed overview of the statutory and case law governing MHRTs see Bartlett and Sandland (2007), Butler (2009), and Jones (2008). For an overview of the law in regard to restricted patients see Scott-Moncrieff (2003).



criteria for continued detention under the MHA are met' (McMurrin, 2009:166). The MHA 1983 as amended by the MHA 1983 (Remedial) Order 2001 (which shifted the burden of proof to the detaining authority following a ruling that the previous criteria were incompatible with ECHR) directs under s72(1)(b) that the tribunal shall direct the discharge of any *unrestricted* patient not detained under section 2<sup>78</sup> if they are not satisfied:

- that [the patient] is then suffering from mental illness, psychopathic disorder, severe mental impairment or mental impairment or from any of those forms of disorder of a nature and degree which makes it appropriate for him to be liable to be detained in hospital for medical treatment (s72(1)(b)(i)); or
- that it is necessary for the health and safety of the patient or for the protection of other persons that he should receive such treatment (s72(1)(b)(ii)).

In the case of unrestricted patients, MHRTs are first required to consider if the case for mandatory discharge has been satisfied. If the patient meets the statutory criteria and a case has not been made for a mandatory discharge under s72(1), the MHRT still has discretion to direct the discharge of an unrestricted patient, and under s72(2) 'shall have regard' to 'the likelihood of medical treatment alleviating or preventing a deterioration of the patient's condition'. Much debate has existed however about the applicability of the so called 'treatability test' in MHRTs<sup>79</sup>.

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<sup>78</sup> Section 2 is a civil section that permits admission of a patient for assessment.

<sup>79</sup> See *R v Cannons Park Mental Health Tribunal ex p A* [1994] 2 All ER 659 (CA); *Reid v Secretary of State for Scotland* [1999] 1 All ER 481 (PC); and *Ruddle v Secretary of State for Scotland* [1999] GWD 29-1395; *R (Wheldon) v Rampton Hospital Authority* [2001] EWHC Admin 134; *R (Home Secretary) v MHRT* [2004] WEHC 1029 (Admin).

In addition to the powers of discharge under s72(1), MHRTs also have the power to defer discharge to a future date, and under s72(5) direct that a patient's disorder be reclassified. Further to these powers, a number of recommendations are available to the MHRT, and under s72(3)(a) they may 'recommend that [the patient] be granted leave of absence [under s17 of the MHA 1983] or [be] transferred to another hospital or into guardianship'. Importantly, these recommendations do not have to be carried out by the RMO and the multi-disciplinary team, but should this be the case, under s72(3)(b) the MHRT has the power to reconvene.

While s72(1) gives MHRTs the power to discharge patients, under s72(7) these powers do not apply to restricted patients, except as provided by s73 and s74. Furthermore, while MHRTs 'can, and do, make extrastatutory recommendations' with restricted patients (Bartlett and Sandland, 2007:398) these are informal recommendations which MHRTs do not have the power to enforce.

Under s73(1) the MHRT must direct the absolute discharge of a restricted patient if they are not satisfied that the criteria in s72(1)b are met and under s73(1)(b), 'that it is not appropriate for the patient to remain liable to be recalled to hospital for further treatment'. If a MHRT is not satisfied that the criteria in s72(1)b have been met, but still feels that it is appropriate under s73(1)b that the patient be liable for recall, it can direct under s73(2) that the patient be given a conditional discharge. Under s74 which deals with patients subject to both a transfer and restriction direction, MHRTs have a duty to report the outcome of the hearing to the Secretary of State and to identify if the patient would 'be entitled to be absolutely or conditionally discharged'. It is then dependent on the Secretary of State's consent as to whether the patient will be returned to prison, although under s74(1)(b) the MHRT can recommend that they remain in hospital.

Previously, and under the MHA 1959, MHRTs did not have the power to discharge restricted patients, and instead could only make recommendations to the Secretary of State. Following *X v United Kingdom* (1981) that found the inability of MHRT to discharge restricted patients to be in breach of the European Convention on Human Rights (ECHR), the role of MHRT was extended under the MHA 1983 so that MHRTs now have the power to discharge restricted patients. However, it is clear that the Ministry of Justice and the Secretary of State still have numerous powers in regard to restricted patients in that they can prevent the RMO from authorising leave, transfer and or discharge, and prevent the MHRT from directing the discharge of patients subject to transfer and restriction direction, and making formal recommendations for other disposals. The Secretary of State's permission is also needed to return patients to prison and recall restricted patients to hospital. This highlights that MHRTs have limited powers in respect of restricted patients (Richardson, 1993) and that the situation for transferred prisoners seeking discharge from hospital, is 'even more dire' (Scott-Moncrieff, 2003).

### **Previous research on Mental Health Review Tribunals**

Research concerning the decision-making of MHRT is relatively absent in comparison to studies concerned with the decision-making of other criminal justice institutions, including the courts and the PB (Holloway and Grounds, 2003). The most comprehensive research concerning MHRTs is provided by Jill Peay who has considered the operation and decision-making of MHRTs under both the 1959 and 1983 Mental Health Acts. Other MHRT research includes: Richardson and Machin (1999, 2000a, 2000b) who considered the structure and procedure of MHRTs; Ferencz and McGuire (2000) who considered how MHRTs are experienced and perceived by patients and MHRT members; Perkins (2003) who considered the decision-making of MHRT in relation to unrestricted patients detained under section 2 and 3 of the MHA

1983; and Holloway and Grounds (2003) who explored MHRT decision-making with restricted patients.

In line with the findings of Peay (1989) Holloway and Grounds (2003) found that the variable with the greatest impact on discharge or recommendation for transfer was the RMO report. This highlights that legal and lay members often rely on clinical judgment and that the RMO plays a 'pivotal role' in determining when a patient is suitable for release (Ferencz and McGuire, 2000). Holloway and Grounds (2003) found that tribunals rarely went against the advice of the RMO, and if they did, this was usually in order to take a more cautious approach. The impact of an IP and their report on the MHRTs decision has been found to be minimal (Peay, 1989), although some research has found that MHRTs were more likely to discharge if an IP was present, especially if they were proposing to be involved with subsequent supervision (Holloway and Grounds, 2003).

Prior to the hearing, the medical member must assess the patient. Many have observed that this is problematic as it requires the medical member to undertake a number of conflicting roles because they are required to act as an expert, witness and decision-maker (Holloway and Grounds, 2003; Peay, 1989, Perkins, 2003; Richardson and Machin, 2000a). Some of these roles are medical and others legal and this places the medical member in an ambiguous position. Perkins (2003) found that despite medical members being aware of the correct procedures in interview, observation suggested that they frequently disregarded the MHRT Tribunal Rules 1996 by giving direct opinions on the suitability for discharge. This is important because the evidence of the medical member can have a significant influence on the review, but the medical member is not open to cross-examination by the patient (Holloway and Grounds, 2003).

The extent to which the statutory criteria and extra-legal factors affect MHRT decision-making has been subject to much debate. Some of the earliest research on MHRTs by Fennell (1977) found that 'common sense' factors had more impact than legal factors, which often provided little more than 'short hand reference points'. Later research by Peay (1989:137-8) confirmed this, and identified six factors that appeared to influence MHRT decisions with patients detained under the category of psychopathic disorder, namely: the opinion of key individuals, particularly the RMO, medical and legal members of the tribunal; the 'passage of time', that is whether the patient had 'passed the appropriate threshold to enable a decision to be made realistically about his risk'; the seriousness of behaviour; the question of evidence; the intentions of the tribunal; and finally, the concept of future control. Perkins (2003) found that the presence or absence of symptoms, insight, compliance, co-operation and risk and danger to self and others were the most important factors to consider in relation to the decision made. Holloway and Grounds (2003) observed that insight to offending behaviour, ability to show remorse and marital status all had an impact on tribunal decision-making and suspected that the physical appearance of patients also influenced the decisions made by MHRT panels.

For the majority of patients, discharge from hospital is a process rather than a single event, and patients are often given a leave of absence before being discharged (Bartlett and Sandland, 2007) with tribunals found to most often prefer to recommend transfer rather than discharge (Holloway and Grounds, 2003; Peay, 1989). This demonstrates that there is often an expectation that patients will travel through the different levels of security, despite the fact that some research has found that many individuals with personality disorder are more likely to be discharged directly into the community (Davison et al, 1999; Special Hospital Services Authority, 1995; Reiss et al, 1999).

Holloway and Grounds (2003) identified that decisions not to discharge were often related to failures of communication amongst tribunal members. Although group decision-making is often considered to be better than individual decision-making, 'group decisions rarely represent an "average" of those parties concerned' (Peay, 2003:124). Holloway and Grounds (2003) found that lay members were often ignored, and that the level of their involvement was linked to their personality. This highlights Peay's (1981, 1989) findings that the attitudes and knowledge of individual tribunal members was a key factor in decision-making. Indeed:

[e]ven though tribunal decisions are made by three people acting together, members' individual 'track records' of real decision-making and their decisions in the hypothetical case were related to their knowledge, attitudes and conceptualization of their role (Peay, 2003:123).

Research has found a generally negative perception of Secretary of State statements amongst tribunal members. Drawing from correspondence with the Home Office, Scott-Moncrieff (2003:271) considers the impression given by the Home Office<sup>80</sup> is that it 'does not consider the tribunal decision to be a determining factor in its decision-making'. This reflects the imbalance of power between the Ministry of Justice who are concerned with public protection, and health professionals who consider their role to be the treatment of patients (Snowden and Ashim, 2008). Bartlett and Sandland (2007:367) argue that:

the powers given to the Secretary of State provide an example of the limitation of medical power and clinical discretion concerning restricted patients, with the

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<sup>80</sup> At the time of Scott-Moncrieff's review chapter, the Home Office and Home Secretary were responsible for providing guidance and statements to the MHRT. Following the government reshuffle in May 2007, this is now the responsibility of the Ministry of Justice and the Secretary of State for Justice.

implicit message that the clinical gaze fails to consider appropriately all factors relevant to the discharge of presumptively dangerous patients.

### **Summary of DSPD patient sample and experience of MHRT review**

Of the forty-six patients who consented to the study twenty-four had experience of twenty-eight MHRTs since admission to DSPD. A number of different legal statuses were found amongst the patient population, with only three of the twenty-four patients (1001, 3016, 3024) originally detained under a restricted hospital order (s37/41). The remaining twenty-one had originally been transferred from prison under s47 or s47/49 of the MHA1983, although a few had been transferred elsewhere in the MH system before arriving in DSPD. The sentences that participants had been serving in the Prison Service varied enormously. Of the twenty-one participants with an original criminal justice disposal, sixteen had been serving a determinate sentence with a sentence length of between fifteen months and six years, while five had been serving a life sentence, with a tariff of between six and ten years. Of those serving a determinate sentence, five had been recalled on license back to prison from the community, before then being transferred to the mental health system.

Although at the time of admission to DSPD, one patient was detained under s37, two under s37/41, three under s47 and eighteen under s47/49, by the time of a DSPD review a number of patients had become unrestricted. By the time of the first MHRT review for each patient, ten of the eighteen patients detained under s47/49 had passed their EDR and were detained under s41(5) (commonly referred to as a notional s37). In other words, while four patients had entered DSPD as unrestricted patients, at the time of their first MHRT fourteen of the twenty-four participants were unrestricted. This reflects the large number of determinate sentence prisoners in the sample and that many of them had been close to their NPD / EDR when transferred to the mental health system.

Most patients had experience of only one MHRT, although four patients had two MHRT since their admission to DSPD. Of the twenty-eight reviews, twenty-three followed an application by the patient or his solicitor and five were the result of a Secretary of State referral. It was apparent that patients and their solicitors sought several outcomes from the MHRT. Of the twenty-eight reviews, fourteen accepted that the statutory criteria were met, but were seeking a recommendation for transfer to another hospital: eight sought a transfer to a medium secure unit (MSU) on the basis that their risk could be safely managed in conditions of lower security; while six were seeking a recommendation for transfer to another high or medium security hospital. This was for a variety of reasons including dual diagnosis, to be closer to their family, or because they did not 'trust' the treating team. In ten reviews, the patient and their solicitors argued that the statutory criteria for continued detention in hospital had not been met and were seeking a discharge (either back to prison or the community depending on the section) on the basis that: in eight cases, that they should not be liable for treatment and/or that they did not have a personality disorder; or in two cases that the diagnosis of personality disorder was correct but that it was not of a nature and/or degree that justified the current detention. The approach and possible legal challenges for four reviews were unclear from the MHRT reasons, although it is of note that two of these reviews were reference hearings, and at least one participant was unrepresented.

In contrast to prisoners with experience of a PB review, some participants in the mental health system were recommended for transfer to conditions to lower security and/or discharge to the community. Five broad MHRT outcomes were found: one of the twenty-four patients was given an absolute discharge into the community (1001); one a recommendation for an absolute discharge, which, with the Secretary of State's consent, led to the patient's return to prison (1020); five a formal (3002) or informal



(1006, 1022, 3015, 3024<sup>81</sup>) recommendation for a MSU transfer; one a direction for reclassification from psychopathic disorder to psychopathic disorder and mental illness (1019); and the remaining sixteen patients given no formal recommendations for either transfer or discharge by the MHRT. Within these non-recommendations the MHRT reviews were considered to serve other purposes.

### **MHRT members' experiences of MHRT reviews with DSPD participants**

A total of forty-six MHRT members were identified from the records of consenting patients, and invited to take part in the study. Sixteen were legal members, fifteen medical, and fifteen lay. Of these, three legal, two medical and seven lay members gave their consent to the study. It is interesting that a low number of legal and medical members and a high number of lay members consented to an interview, as this was broadly similar to the response rate of different types of PB member. Depending on the preference of members, interviews were conducted over the phone or face-to-face. Digital recordings were made and transcribed of all but one interview.

Members had varied careers outside of their MHRT work. Several members had retired from their previous careers, and many had had their three year term as a MHRT member renewed. Perhaps the most significant thing about the MHRT sample in comparison to the PB sample was the dual roles and close involvement of some members with other aspects of the governance of DSPD participants. A few legal and medical members also had experience of 'sitting on the other side of a MHRT' in their capacity as an IP or as a solicitor representing a DSPD patient<sup>82</sup>. These dual roles of legal and medical members highlight that DSPD decision-making is governed by a small number of individuals.

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<sup>81</sup> 3024 received two informal recommendations for transfer to a medium secure unit at two separate MHRT reviews.

<sup>82</sup> One member had also previously sat on the PB.

Members suggested that they most often focused their attention to relevant expertise and reports. One lay member highlighted the importance of the evidence of the ASW for MHRT reviews and then added that that was because he as a lay member was usually expected to question the ASW while the medical member would question the RMO (MHRT3, Lay member). This also illustrates that members often deferred to other specialist members regarding legal and clinical issues. It was apparent that many psychiatric and lay members deferred questions regarding the statutory criteria and law to legal members, while, legal and lay members often deferred clinical issues to medical members. Interestingly, several members observed that medical members' understanding of the issues raised by DSPD may be limited, on the basis that many of the psychiatrists who sat on the MHRT were not forensic psychiatrists, so much of their understanding of (DS)PD was likely to be based on what they have read rather than clinical experience. It is also of note that several members privileged legal members as having relevant experience of individuals with personality disorder, on the basis that many of them had experience of sentencing and making decisions about offenders with personality disorder in Court (MHRT2, Lay member; MHRT11, Medical member).

Generally, members felt that the information from the DSPD units was comprehensive. One member noted that:

I think the reports are quite good and quite full but then you would generally expect that of [name of hospital] ... the social workers and the doctors are generally pretty experienced ... [and] ... know what it is the tribunal want and need to hear (MHRT4, Lay member).

Most often the only criticism was about the volume of information, with a few noting that if they had any complaints it was that there was too much (MHRT11, Medical member; MHRT9 Legal member). A few members identified that more information would be

helpful, and interestingly one member noted that his retirement made it more difficult to know what was going on in current mental health practice (MHRT1, Lay member). This is an important observation because several PB and MHRT members who have retired do more work for the PB and MHRT than other members. Another member highlighted some of the other problems that information could present for the tribunal:

We're given huge amounts of information, some of which can be quite misleading ... quite often a historical incident upon which the clinicians sometimes rely, and previous tribunals have relied are, are disputed events ... frustrating for everybody, not least the tribunal when it, it gets regurgitated tribunal after tribunal report when actually there has been a finding two or three years previously that there was no merit in [it] ... and I can understand they [the patient] feel you know, there's no progress, there's nothing happening at all, and the same incidents are being regurgitated without any critical analysis and ... think the system is against them (MHRT9, Legal member).

This highlights the dangers identified by Munby J ([2005] EWHC 589, quoted in Bartlett and Sandland (2007:393)) of the 'the well known problem that constant repetition in "official" reports or statements may, in the "official" mind turn into established fact something which rigorous forensic investigation shows in truth is nothing more than "institutional folk-lore"'. This also draws attention to one of the concerns identified by previous research on MHRTs, that preliminary decisions made on the basis of reading the reports pre-hearing rarely change, even if the tribunal is presented with conflicting information (Peay, 1981, 1989, 2003; Perkins, 2003; Holloway and Grounds, 2003).

Peay (2003:124) found that 'decision outcomes were best predicted by the member's initial response to the written materials, and remained so despite the presentation of new evidence'. It was not unusual for the MHRT decision-making process to be 'back

to front' on the basis that an outcome was decided and then evidence was used to support that view (Peay, 1989:212). Although, like PB members, MHRT members were keen to assert that they were as thorough with DSPD reviews as they would be with any other, it was evident that members had often made a preliminary decision prior to attending the MHRT review. One member observed:

I mean you can possibly have made a preliminary decision before you go in mentally thinking gosh this person has got no chance at all (MHRT3, Lay member).

### **The significance of DSPD for MHRT decision-making**

While DSPD was framed as presenting unique issues to the MHRT, members were keen to demonstrate that their approach, and the process of decision-making was no different than it would be for other tribunals. This accords with the observation of many PB members that DSPD does not change the process of decision-making. Several members identified that the job of the tribunal was to assess if the statutory criteria for detention had been made out, rather than to judge the merits of a particular treatment service. One lay member observed:

The job of the tribunal isn't effectively to say whether or not that particular service is good or bad or whether ... the treatments they have been given are necessarily the right ones. What we have to determine is whether that person should ... remain under section of the Mental Health Act at that particular point in time (MHRT2, Lay member).

This was identified by other members including those with a background of forensic psychiatry:

What you don't do in a tribunal is say: 'What's the scientific evidence that this thing will work?' We don't do that. We just assume that that's the standard professional approach and accept that that's the treatment (MHRT12, Medical member).

In a similar vein a legal member noted:

It doesn't change obviously the way in which a tribunal has to assess the individual circumstances of a patient ... what you would have as an advantage is a reassurance that the specialised unit better caters for the patient but you'd still have to make as best you can, an objective decision about dangerousness (MHRT9, Legal member).

These statements from lay, medical and legal members indicate that members were keen to emphasise that their primary role was to assess whether the legal criteria for detention had been met. These observations also highlight that MHRT members are interested in the 'here and now' (Peay, 1989:78) and seek to assess each case on an individual basis. Although members were keen to emphasise that DSPD did not change the process of MHRT decision-making, members nevertheless held conflicting views in regard to the significance of DSPD services. That participants were able to get appropriate treatment was highlighted as very important by one legal member, who noted that:

The Dangerous and Severe Personality units are self-evidently ... a help ... The new unit in Broadmoor it seems to me, is impressive ... and consequently provides better services for those identified as being in that category (MHRT9, Legal member).

This view was also present in some of the MHRT decision outcomes, with the observation made in one review that:

Since the time of sentence, views as to the treatability of psychopathic disorder such as the patient suffers from have moved on, notwithstanding that such a condition may be still described as 'treatment resistant'. Pioneering units have been set up, as for example at Broadmoor and Rampton to deal with such conditions. They are known as DSPD units (3015, MHRT decision).

However, this view was not shared by all members, with some members presenting the DSPD units as perhaps no better than any other unit within the high security hospitals. One member observed:

I didn't get the impression that any of the people who were in it were any happier than they might have been in say another ward. I just wonder whether they think they're there for a long time, but that's a sort of gut feeling, they think that, you know, this is the last chance saloon type of thing (MHRT3, Lay member).

The significance of the high security location of Broadmoor and Rampton was identified by several members who pointed out that discharge to the community from the high security hospitals was rare for all patients, not just those detained in a DSPD unit. Like PB members, MHRT attached significance to the physical location of the DSPD units, and the additional security features of the new build DSPD units. One member commented:

I suppose there is an assumption when you're sitting in Broadmoor that the very fact that you're sitting in Broadmoor the case is more or less laid out that the

person is a risk to others and therefore they can continue to be detained (MHRT11, Medical member).

Another psychiatrist in a similar vein noted:

You know it's a special hospital therefore you have to think twice before you let them out ... you're thinking: 'there's got to be something that's alarmed somebody somewhere'. So you've got to treat it with some gravity. I mean you'd be foolish not to give it proper weight (MHRT12, Medical member).

These comments indicate that like PB members, MHRT members have an expectation that high security patients including those detained in DSPD, must undertake a journey through the different levels of security, and that their risk should be tested at various stages, before they are suitable for discharge to the community. One lay member observed:

The normal route ... is to be weaned down to medium security for 4-5 years, then go to a low security, then go into some assisted establishment in the community, 24 hour assisted establishment. So it's a long process (MHRT5, Lay member).

These statements also suggest that risk, and risk assessment were key concerns for MHRT members. There are a number of risk assessment tools that play a central role in decision-making about discharge of patients from forensic hospital settings (Snowden and Ashim, 2008). One member noted:

I think for fairly obvious reasons, risk assessment is probably one of the big things we have to deal with. Particularly if we are mindful to consider discharge or moving to less secure (MHRT7, Lay member).

Some members appeared very sensitive to their responsibilities to the public, and also anxious about the media attention that MHRT cases can generate. One member noted:

I think tribunals are very aware of the responsibility they carry and occasionally we talk about well if we've got it wrong we'll have *The Sun* chasing us around the country trying to find out who sat on that tribunal (MHRT1, Lay member).

Some members were anxious about the extent to which MHRT rely on risk assessments, arguing that risk assessments could be unhelpful on the basis that patients were unable to change their static risk factors. One member also felt that tribunals were in some respects dishonest because they focus predominantly on 'risk' rather than the statutory criteria (MHRT8, Legal member). This highlights that in contrast to PB reviews, MHRTs are required to consider more than risk to the public. A common criticism of MHRTs observed by McMurran et al (2009:169) is that they are:

more mindful of risk issues than patient liberty ... [which] ... may create an unnecessary adversarial process in which the patient and his or her legal advocate are pitted against the clinical team rather than working together constructively.

Many members presented the risk factors in DSPD cases as having an 'extra layer', with personality disorder presented as going hand in hand with other key issues like drug and alcohol use. Many members observed that the history of the patient in



childhood and adolescence and their previous criminal record was important for the MHRT. One member observed that:

it's never as simple as this person has X and that's it. If you treat X they're going to be better. There's a whole range of things which are ... obviously drugs come into it and a lot of people drink. But there's other factors or even their home life or whatever, which are going to result in the person being unwell and, and you have to look at those factors. And for a personality disorder again it's a bit more difficult to, to look at. Because you're not sure ... you're not quite clear what's going on (MHRT1, Lay member).

Several members however appeared unhappy with the separate category of psychopathic disorder in the MHA 1983. One member observed that:

Psychopathic disorder well it's very troublesome, but I mean has led to some pretty protracted tribunal hearings (MHRT9, Legal member).

While another member identified that:

I have to say I think an awful lot of members who sit on the tribunal don't really know what psychopathic disorder is (MHRT11, Medical member).

Other members identified that psychopathic disorder was not a label that patients liked to be given (MHRT9, Legal member; MHRT4, Lay member), and that clinicians were wary of diagnosing someone with a personality disorder (MHRT9, Legal member). Members were also frustrated by the label of personality disorder on the basis that it was tautological and that 'everything leads to the next assumption' (MHRT8, Legal member). One member observed:

I think it does a disservice to the, to the great majority of people who are mentally disordered ... to be associated if you like unnecessarily with a group of people whose principal presentation is one of offending ... rather than, you know, a mental illness (MHRT4, Lay member).

DSPD patients were also framed by MHRT members as particularly transient individuals who had often moved about for much of their lives both in the community and within institutions. One member observed that patients often found themselves shunted back and forwards between services, or trapped in one or other. In this sense, patients with personality disorder were framed as being additionally risky, because services had often not wanted to know, and as a result patients were less likely to have received appropriate treatment. Individuals with personality disorder were also treated with some scepticism by MHRT members with one member making the observation that:

Some of these people you are dealing with are extremely clever. They're very manipulative and that's one thing one needs to bear in mind ... I mean some of them just can twist everything, it's just unbelievable (MHRT3, Lay member).

Personality disorder was identified as a significant issue for MHRT making for a number of reasons. One reason, in comparison to other mental illnesses, was that personality disorder could not be treated by medication. Treatment and the ability to assess what works were presented as taking considerable time, and particularly difficult, because:

You're trying to get the person to think differently as much as behave differently. Rather than just behaving as they've always behaved. So it's much more difficult (MHRT2, Lay member).

Some members did not believe that the treatment in DSPD was particularly new or different and that it was just existing treatment 'with a new name' (MHRT8, Legal member). Some members observed that patients did not like the fact that every aspect of their life in the DSPD unit was under scrutiny, and that many patients did not like groupwork. One member who noted that the majority of patients in the high security hospitals had histories of abuse in childhood raised one of the challenges involved with trying to know the DSPD patients:

You just wonder how beneficial it is to go back into their past and to talk about it and bring it all back to them. You wonder whether it's going to help them or make them worse or make them you know, possibly at more risk of harming themselves (MHRT3, Lay member).

The development of DSPD services was in a large part a response to the debates that have surrounded 'treatability'. Interestingly, treatability was raised in only eight reviews, with the MHRT most often used by patients to elicit a recommendation for transfer to lower security. Where treatability was a relevant consideration for the MHRT, many members felt that through case law, that it had become largely irrelevant. One legal member observed that:

It's been watered down so much through case law that it's more or less meaningless now (MHRT10, Legal member).

Another member, a forensic psychiatrist, observed that the treatability test had become fairly easy to meet even when the patient was refusing to co-operate. In his words:

They can only detain him if he's psychopathic disorder, if he's likely to benefit from treatment. But that's so elastic that they can't fail 'cos they say: 'Is he co-

operating?' 'No', 'Will he co-operate?' 'We don't know' ... 'Can you prevent deterioration by keeping him in hospital?' 'Well yes you can, you can stop him raping and all the rest of it'. So ... that's it, game set and match. And so the tribunal can't discharge ... it doesn't have to be treatable. It's treatable or prevent deterioration. We can always prevent deterioration (MHRT12, Medical member).

Members also framed the treatability test as more irrelevant in DSPD cases than other personality disorder cases because the programme was new, and therefore it was harder to discern if the treatment could alleviate or prevent deterioration of the patient's condition. In this sense, members presented as keen to keep an open mind about the treatment programme. One member when asked about the significance of treatability for the MHRT commented:

not really because ... it's relatively new and because they're still effectively looking at the treatability, what they can do, and because ... people are coming in and they're quite complex and therefore they need to get further information, it hasn't really come up ... if a person had gone through a range of treatments and they were still not responding to those treatments, then ... it might be an issue. But when there's still a range of treatments available or they're still trying to find out which treatment is the most appropriate, it hasn't been an issue so far (MHRT2, Lay member).

For other tribunals where treatability had been in dispute, the MHRT clearly had more difficulties in its approach. It was clear that MHRT members were more than aware that treatability was a contentious issue. One member noted:

The patients talk to each other and they understand that treatability is an issue and it's an issue of great dispute amongst psychiatrists (MHRT6, Lay member).

Similarly, the outcome of one particularly lengthy MHRT review, observed:

The tribunal is confronted with an important conflict of opinion among psychiatrists as to whether severe personality disorder is treatable. The instant tribunal hearing is unlikely to achieve a convincing resolution of this conflict. However the tribunal directs itself that:

- 1) The tribunal must not seek to achieve any perceived political purpose of stretching law to authorise detention of persons who have severe antisocial personality disorder who are untreatable, and
- 2) The individual characteristics of 3004 need to be considered carefully to determine whether his individual condition is treatable within the guidance of directed case law (3004, MHRT decision).

Treatability is an important consideration of several of the MHRT reviews and will be further discussed in the context of the different outcomes of MHRTs with DSPD patients, to which the chapter now turns.

## **The outcomes and purposes of MHRT reviews with DSPD patients**

### ***Discharge to community***

It was of note that the only patient to be given an absolute discharge was one of the few participants who had originally been detained under s37/41 of the MHA 1983, and the only participant not to have spent time in the Prison Service since commission of the index offence. At the time of his MHRT he was an unrestricted patient. Of note too,

was that this patient had been one of the original participants in a hospital DSPD unit and at the time of his discharge had spent over four years in DSPD treatment. Perhaps what also marked this participant out from the others was the supportive nature of his parents, a point reiterated in interview with one of the MHRT panel members. Of particular significance, and in line with previous research on MHRTs, was that this patient had the support of the clinical team for his discharge. Indeed, the very brief reasons provided by the MHRT read as follows:

The RMO stated that the patient's condition no longer necessitated the patient's detention in hospital. He was however concerned that adequate steps be put in place in the community to avoid any risk of deterioration of his condition before discharge. The tribunal agrees with the RMO, and to enable the care package to be properly formulated the tribunal defers the patient's discharge (until the end of the month) (1001, MHRT decision).

One MHRT member who had sat on the case identified the importance of DSPD patients undergoing a journey through the mental health system in order for their risk to be tested along the way. This member identified that:

the patient in question certainly had different characteristics to many patients that we sit in front of ... he had superb family support ... it's an indicator for me that things may probably work once back in the community ... the other indicator that I remember striking me about this chap was he fully engaged in all the therapies, he's responded to the therapies, he'd been tested out back in the community ... he was very motivated to still make something of his life ... there was consensus amongst the tribunal that this is a chap who had responded, he's got all these support services around him ... got a future pathway mapped out (MHRT1, Lay member).

***Return to prison***

This case involved a twenty-seven year old man convicted of wounding with intent, assault occasioning actual bodily harm (AOABH) and possession of an offensive weapon. He was sentenced to nine years and seven months in prison although was later transferred to a hospital DSPD unit under s47/49 of the MHA 1983. Within a month he applied to the MHRT to review his detention. Although the RMO's report for the MHRT did not support discharge, the psychiatrist did identify that:

1020 told me that once in the DSPD unit he changed his mind and wished to be returned to prison. He told me that the main reason is his concern that he will be 'stuck' in the healthcare system well past his expected prison release date (1020, Psychiatrist report).

Reports commissioned for this case in the main argued that the patient should remain in the hospital DSPD unit, and these were supported by the Secretary of State's statement. The social circumstances report written by the ASW was more ambivalent about the appropriate placement for the patient, while the IP's report clearly stated that the patient should be returned to prison as he wished, on the basis that there was 'no evidence that DSPD works' (1020, Independent psychiatrist report). In this case the MHRT decision outcome noted that:

Whilst the tribunal accepted the evidence of [the RMO] that the patient is suffering from psychopathic disorder of a sufficient nature and degree for the purposes of this part of the Act, the tribunal was not persuaded that it was appropriate in this case that the patient be liable to medical treatment in detention (1020, MHRT decision).

The reasons given for this decision centred around the MHRT finding that:

the patient has at all times remained implacably opposed to partaking in any form of therapy, in a group or otherwise, and was in the tribunal's view likely to remain so. Accordingly the tribunal decided that the detaining authority had not proved it was appropriate that the patient be liable to treatment in detention because he was not undergoing any treatment in the DSPD unit ... which was likely to alleviate or prevent deterioration of his personality disorders (1020, MHRT decision).

The tribunal advised that if the patient had been detained under another section, he would be entitled to an absolute discharge. This (with the Secretary of State's consent) led to the patient's return to prison to serve the remainder of his sentence, which was due to expire less than a year later. Perhaps the most frustrating thing about this case is that the patient had experienced a transfer to the mental health system earlier in his sentence than many other DSPD patients. Because the patient refused to engage in therapy, and was consequently not considered to be treatable under mental health legislation, it is likely that little meaningful work will have been completed before his NPD and scheduled release from prison less than a year later<sup>83</sup>. Indeed the social circumstances report noted as much:

experience tells me ... that there would be little opportunity for him to be offered therapeutic work in prison (1020, Social circumstances report).

One can only speculate what the MHRT may have recommended if the patient had passed his NPD / EDR and was detained as an unrestricted patient under s41(5) of the

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<sup>83</sup> Although outside the study period it is of note that this patient/prisoner, despite being considered untreatable by a MHRT, was transferred back to the same hospital DSPD unit a few days before his NPD and expected release from prison.



MHA 1983. This question was in fact put to a tribunal member who had sat on the case, who argued that the outcome would have been no different, because the MHRT are there to assess the law. It was notable however that no patient detained under s41(5) was recommended for a discharge even when they too presented as determined not to engage with treatment. This suggests the MHRT may be more likely to exercise discretion if there is somewhere else for patient to go. While most members argued that the legal section under which a patient was detained was largely irrelevant to the decisions that MHRT made, one Judge observed:

When you've got a notional 37 you can't have a 41. The tribunal are much less likely to take a risk with those people because it's all or nothing when you're discharged ... I think it would be much easier to move people forward if somehow a notional 37 could have a 41 attached to it (MHRT10, Legal member).

A few members identified that the legal status of patients may have a clear impact on their motivation and engagement with treatment. This draws attention to a double-bind that some DSPD patients may find themselves in:

If they go back to prison their tariff is up and they could actually get out quicker because in Rampton they can be in there indefinitely. Then of course they've got to get weaned down the system, medium secure, low secure. But if they can be transferred back to prison they can get out a lot quicker (MHRT5, Lay member).

A final and important observation to make in the case of 1020 follows the observation of one member who had been involved with the case, who noted that the decision to return the patient to prison on the basis of untreatability:

was said to have sent shockwaves through the unit because they were concerned that if one person can win a tribunal on the basis of untreatability then lots of patients might disengage ... in fact [the clinical director of one of the units] said exactly that last week. You know, if one patient wins an untreatability then we've got a problem on our hands (MHRT11, Medical member).

This demonstrates the potential impact of MHRT decisions on the DSPD patients and DSPD units. This also suggests that MHRT members are aware of the significance and repercussions of their decisions.

***Recommendation for transfer to medium security***

Five of the patients had been given a formal (3002) or informal (1006, 1022, 3015, 3024) recommendation for a MSU transfer (although two of these could arguably have been classified as no recommendation). The request for conditions of lower security rather than challenges to the statutory criteria for detention suggests that many patients adopt a realistic approach to the tribunal. It is of note that the majority of those given a recommendation by the MHRT for transfer to conditions of lower security were also reported as having made consistent effort and progress with DSPD since admission. This indicates that similarly to the PB, the MHRT will not condone any wrongdoing within the institution, and that DSPD patients need to demonstrate a positive and engaged approach to treatment if they want the MHRT to help them proceed. In the case of 3015 one member who had sat on the panel observed the real progress being made:

There was definite evidence that he was making progress. And we were able to contrast that with some of the statements that had been made about his progress in prison when the opinion that we were given was that he'd gone along to therapies, he'd participated in them, he'd completed the programme

but there wasn't a lot of evidence that he was gaining from it and he seemed to be going, at that time, going through the motions ... but the evidence that we were getting from the psychology department in [DSPD] was that there was definite, you know, progress being made (MHRT7, Lay member).

In this case, the MHRT informally recommended a transfer to medium security on the basis that he did not need to be detained in high security. Importantly, the MHRT decision made the observation that:

We accept that a significant ingredient may be for the patient to have some future to look forward to and that for him, at the moment, is expressed as a path towards returning to normality, a step along which would be a move to conditions to medium security. We note the team's concern that such should not detract from the endeavor to give full engagement. The weight of the evidence before us is that whilst the patient requires the benefit of DSPD treatment, he does not require to be in conditions of security such as at [name of hospital] and on his present unit (3015, MHRT decision).

This demonstrates the importance of time and timetables for long stay patients in the healthcare system (Roth, 1963). This also indicates that informal recommendations from the MHRT were keen to leave the decision and the timing of any transfers to the high security and medium security units and 'clinical judgment'. One MHRT decision letter for another patient given an informal recommendation for medium security, noted:

His progress has been such that his RMO has already referred him to MSU services with a view to transfer. The tribunal supports this stance. While recognising that such transfer is essentially a matter of clinical judgment for the

hospitals concerned and the Home Office, the tribunal recommends that the patient is transferred as soon as is practicable (1006, MHRT decision).

Previous research has demonstrated that MHRTs most often adopt the view of the RMO, and if they reject the RMOs view this is most often in favour of a more cautious approach (Peay, 1989). In most DSPD cases the MHRT agreed with the RMO, however, in one case, the MHRT identified that:

[RMO] is of the view that the patient needs to complete the substance misuse programme whilst detained in conditions of maximum security. However it is the view of [ASW] and [Forensic psychologist] that the patient could be managed in conditions of medium security provided the security is appropriate to the risks the patient presents and that it has the appropriate range of treatments which the patient requires. We share this view (3002, MHRT decision).

This outcome may suggest that increasing privilege is being given to psychologists in the treatment and risk assessment of those with personality disorder. Some PB and MHRT members however, still appeared more confident with placing their trust in psychiatrists, and ambivalent about the role of psychologists.

In another case, the MHRT commended the patient for his behaviour and engagement with DSPD treatment since admission (1022, MHRT decision). The MHRT noted that it was proposed that the patient should complete the Sex Offenders Management Programme (SOMP) and a Violent Offender Programme, and that the unit had taken the first steps towards consideration of a medium secure placement. The MHRT felt that 'the SOMP should be completed before transfer in order to reduce the risks which a transfer to conditions of lesser security would bring' (1022, MHRT decision) but hoped that assessment for transfer could be completed by the time the patient had

finished the programme. This case illustrates that MHRTs can adopt a bargaining role by informally recommending transfer to lower security providing certain treatment is completed.

The case of 3024 was also particularly interesting as he was the only participant given two recommendations for an MSU, despite being reported at both MHRT reviews as not engaging and as wishing to be transferred. At the first review, the MHRT noted that while they felt DSPD was the best placement available to 3024, the evidence did not suggest that he needed to be in conditions of such high security. By the second review, the MHRT noted:

We are satisfied in the words of [RMO] that a 'therapeutic impasse' has been reached with 3024 ... we make no criticism of [RMO] or of any member of the clinical team. We are sure they have done everything possible to try and persuade 3024 to engage in treatment. Indeed we are bound to express concern as to whether a change of institution will produce any long term change in his attitude. At the same time as [RMO] is prepared to look at both the option of the patient being assessed by [another high security hospital, and] ... the possibility of a transfer to medium security conditions if the necessary funding can be obtained. We can only endorse this approach as being in the patient's longer term interests (3024, MHRT decision).

Of note here is that while the patient received an informal recommendation for a transfer to medium security as he wished, the MHRT are keen to point out that his lack of progress is not the fault of the unit, and express future doubt and concern that a transfer will lead to a change in the patient's attitude and progress. This may be an attempt to encourage the patient not to end up in the same situation in the future if he wishes to make further progress.

***Reclassification of mental disorder***

Following the advice of the RMO, the MHRT directed that one patient, who had been referred to the MHRT and was recorded as having ‘made it quite clear that he didn’t want anything from the tribunal ... [as] ... he accepted the reports and ... was prepared to work with the medical team’ (1019, MHRT decision), should have his mental disorder under the MHA 1983 reclassified from psychopathic disorder to psychopathic disorder *and* mental illness. The MHRT also supported the RMOs plans to move the patient from the DSPD unit to another high security hospital, better equipped to cope with the presentation of the patient’s mental illness.

***No recommendation***

The majority of patients received no recommendation for a transfer to lower security or discharge to the community. Of those who did not receive a formal recommendation, the majority were seeking a transfer to another hospital, most often one in medium security. A few patients were arguing that they did not meet the criteria for detention, most often on the basis that treatment was failing to alleviate or prevent deterioration of their conditions, that they did not meet the criteria for psychopathic disorder, or if they did, that it was not of a nature and/or degree that justified detention in hospital.

Several of the participants who received no recommendation from the MHRT had been particularly disruptive and unco-operative since admission to DSPD services. Often this behaviour was interpreted by the MHRT as a result of a late transfer from prison. One patient who had experienced a late transfer was recorded as being:

Extremely angry, he was not going to co-operate ... he was, is a psychopath without a shadow of a doubt, and of course he was a sex offender as well. And he’d done all these various courses and it had had absolutely no effect upon him at all. He was I think unmanageable in the community and I think quite

rightly they were extremely frightened of what would happen if he were released. But you've got to look at his point of view too, he wasn't going to co-operate in any way at all (MHRT3, Lay member).

This quotation demonstrates the double-bind that not only DSPD patients may find themselves in, but also the authorities responsible for public protection. While MHRT panels made reference to the problems that late transfers may create for patient engagement, and extended empathy to the patient for the situation they found themselves in, they would not condone any wrongdoing in the institution. Sometimes they suggested why transfers may have taken place, perhaps for the purpose of encouraging the patient to take responsibility for their own predicament. For one patient recalled from the community to prison, and then transferred to the mental health system before the end of his determinate sentence, the tribunal observed:

We understand that insofar as his recall was based solely on driving without insurance and without a license, the patient is entitled to feel aggrieved; and we understand too, his feelings about finding himself subject to the Mental Health Act at such a late stage of his sentence, but the evidence demonstrates that in a number of respects he was not fully compliant with the requirements of his hostel while on license (1015, MHRT decision).

For another patient, the MHRT observed:

Since admission to [the DSPD unit], there have been numerous incidents of threatening and abusive behaviour. In fairness it should be said that some of these outbursts may have been borne out of frustration induced by the lateness of his transfer ... although it is noteworthy that he behaved in a similar fashion in prison (1016, MHRT decision).

The case of one patient, adjourned by the MHRT, highlighted the therapeutic potential of MHRTs. Peay (1989:223) argues that MHRT reviews can serve a relief function by helping to 'satisfy the patient's need for information or clarification and help to diffuse tension' (Peay, 1989:223). In this DSPD case, the MHRT was adjourned on the basis that:

The patient had been transferred to [DSPD] on the day of his release from a modest prison sentence. He was understandably angry and he has had no independent assessment of his case. Although the application came late in the day we felt that it would be just to grant it and that it might have some therapeutic effect (3023, Adjourned MHRT decision).

Several of the patients who had no recommendation from the MHRT had argued that they did not meet the criteria under the MHA 1983 for detention, most often with the support of IP reports arguing that they were 'untreatable' and therefore should not remain liable to detention in hospital for treatment. In all these cases, where the MHRT gave no recommendation, the evidence given by the IP was rejected in favour of the RMOs evidence. In response to arguments that the patient was untreatable, MHRT panels either decided that the patient was capable of choosing to engage in treatment, or that they were treatable on the basis that they had not completed any treatment in the Prison Service, and therefore their ability to benefit from treatment was as yet unknown. In one case, the MHRT observed that while the patient was not participating in treatment, he could if he so wished. Indeed:

The tribunal does not accept that 3004 is not treatable unless he engages in such work. If, as the tribunal is satisfied, he is capable of choosing to engage, he is treatable in this sense, as well as being treated by benefitting from the general ward and nursing environment (3004, MHRT decision).



The view that patients are treatable on the basis that they have the capacity to choose to engage was identified by another tribunal. MHRT reviews appeared to make DSPD patients responsible for their response to treatment, and would often point out to the patients that their approach to treatment and/or the MHRT may be hampering their opportunities of progressing towards release. In the case of 3024 who was seeking a transfer to another hospital, the MHRT identified:

While there is co-operation it is very limited and the patient is deriving very little benefit. We have no doubt that 3024 has the intelligence and capacity to fully engage with and benefit from treatment. We are also sure that his present attitude is harming his prospects of moving on perhaps to conditions of lesser security (3024, MHRT decision).

The treatability test was satisfied in other ways, with several panels highlighting that DSPD patients had completed little or no offending behaviour work while in the Prison Service, and for this reason could not be said to be untreatable, and therefore could continue to be detained in hospital. This reflects the 'hidden agenda' at many MHRTs dealing with patients with psychopathic disorder, and that 'the potential benefits of treatment do enable tribunals to accommodate decisions which result in offender-patients remaining in confinement as reluctant clients' (Peay, 1989:137). For one participant, whose solicitor was arguing that he was not treatable, the tribunal noted that:

He has never previously had the opportunity to participate in such a programme, which is likely to be beneficial to him ... it may be difficult to get the patient to engage in psychological therapy as in the past he has been resistant to it and is unwilling to discuss his problems, particularly his sexual offending,

but it seems to the tribunal that the DSPD represents a realistic chance for him to tackle his previous patterns of criminal behaviour (1016, MHRT decision).

In the case of another patient, the MHRT decided:

1005 has not completed (or been offered) any courses to address his sexual and violent offending risks during his lengthy and repeated terms of imprisonment. Indeed if he has been offered such courses within prison they have subsequently been withdrawn (because of his diagnosis of personality disorder). This then, constitutes his first presentation to psychiatric services and the first occasion when he has been offered meaningful psychological and psychiatric intervention (1005, MHRT decision).

Previous research has identified that MHRTs are used for more than clarifying whether detention is legal under the MHA 1983, and can often perform a number of subsidiary functions (Peay, 1989). The importance of the MHRT as a mechanism for helping participants progress through DSPD services was evident during several interviews. One legal member commented:

It's no fun being on a tribunal if you're unable to do anything positive (MHRT9, Legal member).

The same member observed that one of the purposes of tribunals was to help:

move people on, not necessarily physically, but mentally sometimes ... to help them and to give them encouragement in what they're doing. That's part of the tribunal function, and obviously a tribunal function is, it is an outside independent body of the hospital overseeing what is happening ... I mean, we

don't want to be too starry eyed about the fact that sometimes we are pretty powerless in what we recommend, but we have a go (MHRT9, Legal member).

In a similar vein, another member reiterated:

By the way we do discharge patients as well! ... It's one of the things that has impressed me. It's not a paper exercise that we go through. It's very much a hearing for the patient to make sure what's happening to him or her is the right thing ... for them and ... for the public (MHRT7, Lay member).

Often, the MHRT appeared to use the review to encourage DSPD staff to take certain courses of action. This highlights that MHRT are sometimes used by patients as a catalyst to elicit better information from the RMO and the institution (Peay, 1989). In this sense, MHRTs can be seen as 'auditing' the work of the RMO (Langley, 1993:336). For one patient, the written reasons noted:

It was unclear to the tribunal exactly what part 1005 played in these events, as rather surprisingly, the professionals here at [name of hospital] have not been able to access the original case papers (1005, MHRT decision).

For another patient, while the MHRT made no recommendation, they did nevertheless identify:

The patient himself wishes to transfer to [name of high secure hospital] to enable his family to be closer to him and to enable them to visit. We consider that should be urgently explored. We also consider that there is a need for urgent discussion with the patient as to what further work is needed and what

further progress is required before he will again be assessed as suitable for a possible transfer to an RSU [Regional Secure Unit] (3028, MHRT decision).

This statement illustrates that MHRTs can function as ‘negotiators and brokers, acting informally behind the scenes to “move things along”’ (Peay, 1989). The MHRT also used the review with DSPD patients to identify areas for further treatment, to commend patients for their progress so far, and to encourage their continuing engagement and motivation. This highlights the importance of benchmarks and providing patients with a clearer idea of progression timetables (Roth 1963). For one participant seeking a recommendation for transfer to a medium secure unit (which the tribunal believed was premature) the panel nevertheless observed that:

We consider that 1005 is to be commended for the entirely realistic (and for this specific purpose) insightful way in which he approaches what is his first application to the tribunal. We are unable today however to acceded to 1005’s request that we make a formal recommendation for transfer to medium secure services ... Very appropriately however, the treatment team have invited clinicians to come and assess 1005 ... we accept from 1005’s evidence, a noticeable difference in 1005’s confidence and ability to interact with others. We would finally note the obvious importance of striving for treatment provision in the least restrictive environment, located as close as possible to both 1005’s father and his partner (1005, MHRT decision).

This suggests that the MHRT is keen to encourage patients to continue with realistic and positive approaches to both treatment and the tribunal process. It is important to note that tribunals can also be used as a therapeutic tool by RMOs to help encourage their patients into treatment (Peay, 1989) as demonstrated by the following observation

made by the MHRT for one patient undergoing his second review since admission to DSPD:

Initially 1015 was refusing to participate in any therapies on offer. However ... after his last Mental Health Review Tribunal – 1015 has been participating (1015, MHRT decision).

These observations highlight that MHRTs are keen to encourage patients and the unit to reach a stage where progress to lower security facilities is possible. Several MHRT outcomes made reference to the fact that the clinical teams in DSPD had either begun or would soon begin to liaise with services in medium secure services. Evidence of liaison between the DSPD units and other mental health services is clearly important for the MHRT. One member described the liaison of the DSPD units with services in lower security was an area where MHRTs could 'flex their muscles' (MHRT1, Lay member. It is also of note, that on the rare occasions that family members were involved with the patient's care and/or MHRT review, the panel made a positive note of this.

### **Anxieties about the journeys of DSPD patients**

One of the biggest anxieties about DSPD services for MHRT members was the transfer of determinate sentence prisoners to hospital DSPD services at a late stage of their sentence. MHRT members expressed concern about the implications of this for patient behaviour and engagement with the DSPD unit. In the MHRT reasons, panels often noted the late stage of transfers, although, like members in interview, also acknowledged that these were not issues for the MHRT. Indeed:

Given the late stage during his prison sentence at which 3004 was transferred, it was predictable that he might feel aggrieved. This was not conducive to

positive engagement in treatment. However these concerns do not determine the issue of whether his condition is appropriate for detention under the MHA 1983 (3004, MHRT decision).

In interview members were keen to raise their concerns about this practice and how they felt that late transfers were not conducive to encouraging participant engagement and co-operation. One lay member from the MHRT noted:

We all thought that it was supremely unfair to him to have transferred him at a very late stage ... without any warning at all. And the sort of general comment was, how the hell do they expect the unit to operate with such an angry patient ... I just felt he might have taken his case to the [European] Court of Human Rights quite frankly, and I think some of the others might well do so. If you get one particular barrister who thinks this kind of transfer is wrong, I wouldn't be a bit surprised if it happens (MHRT3, Lay member).

This highlights that some members believed that the practice of transferring prisoners at the end of a prison sentence to hospital DSPD units may lead to legal challenges. Other members described the practice as 'coerced treatment' (MHRT8, Legal member), and likened it to 're-sentencing' (MHRT8, Legal member; MHRT12, Medical member). One forensic psychiatrist observed that the DSPD units generated:

a great deal of unease really. The locking up of people with psychopathic disorder would be all right, it seems to me, if they were sent there by the court ... that would seem to me open and fair. What's uncomfortable about the present system is that on the executive say so the doctors at Broadmoor, the Home Secretary and the Prison Authorities, can shift him into this system, which is effectively a life sentence, without a Judge being involved ... the Court

has already sentenced him properly for the offence so they're re-sentencing him effectively. And I can't see that that's right (MHRT12, Medical member).

Members were particularly anxious that patients were resentful of late transfers, and that they were unlikely to gain the much needed motivation from participants to engage in the treatment programme. A few members also expressed concern about the challenges that it may present for DSPD staff. One psychiatrist, when asked if late transfers to the mental health system had any implications for the motivation and engagement of participants, observed:

Of course it does 'cos he says: 'I'm stuffed if I'm going to co-operate with them' ... And they [the unit] say: 'Chum you stay here until you do' ... [so it's a] ... very difficult position for the patient. Difficult for the staff and in terms of natural justice (MHRT12, Medical member).

Aside from the ethics of late transfers to the mental health system, most members, appeared to feel that until patients had engaged with and completed the DSPD treatment programme, they were unlikely to be considered for a progressive move. One member, when asked how the tribunal may respond to somebody refusing to engage, made the observation that:

well that isn't going to go very well for them at all; if they want a recommendation for example, that's not going to go well at all (MHRT5, Lay member).

The need to complete DSPD treatment before transfer to conditions of lower security was highlighted during interview with another member, who commented:

I get a sense that they feel that they've got to engage in the programme if they want to get brownie points to help them through their pathway ... and I think it's how you work through whether there's a genuine motivation in all of this rather than ticking another box which you can put in front of a tribunal ... I mean as I say, one of the things I like to do is question the actual patient ... what have you learnt ... how has it changed you? Convince me that it has made a genuine difference to how you perceive life (MHRT1, Lay member).

This illustrates that some members were sceptical at the ability of DSPD patients to make the necessary changes. A few members saw the future as fairly bleak for DSPD participants in that they were unconvinced that they would be able to reduce their risk to an acceptable level. Another member observed:

It's impossible to know when they're ready ... it's impossible to tell because they jump through all the hoops. You give them these training programmes. They jump through it. They say all the right things. Their behaviour on the ward becomes immaculate and you let them out and they re-offend (MHRT12, Medical member).

Although MHRT members presented as far more flexible in regard to DSPD treatment when compared to PB members, some MHRT members reported that they were anxious about the weight given to programme completion and the presence of a 'tick box mentality'. The issue of where the treatment received in a DSPD unit may fit with other traditional treatment programmes was raised in one patient's case, but it was evident that the MHRT were prepared to take an individualised approach. In this case, the tribunal identified that:



there may be a fundamental misunderstanding here and the debate about the patient having 'completed' and 'successfully completed' various sex offender therapy programmes ... it is clear to us however different it may be, the treatment received by the patient is working and producing positive results ... he declared that whatever may be proposed he would undertake, expressing understandable reservation about what that might be, or appear to be, pointless repetition (3015, MHRT decision).

This statement highlights that some MHRT members had concerns about repetition. Although the DSPD units had often provided information about the patient's reduction of risk, some MHRT members, like PB members, appeared anxious about how they and the units were supposed to make sense of the risk, and reduced risk of DSPD participants. One psychiatrist recalled a MHRT where:

about two months before the tribunal it was identified that he had a number of videos in his room and interspersed between just standard films were scenes of rape and extreme violence ... but when the psychologist came to give evidence to the tribunal, it was her opinion that yes he had completed the SOTP, he had made wonderful progress, and of course the question was well why on earth do you think he recorded these videos and she was unable to say. And it just doesn't seem real that you can say someone has made outstanding progress on an SOTP programme if he still does that ... I mean what does progress mean if that's the case? (MHRT11, Medical member).

The accurate assessment of risk was also presented by several MHRT members as more difficult because of the high security conditions of the DSPD units. One member noted:

some of these patients yeah they may be over the last let's say 5-6 years totally compliant, no problems at all, not a management problem, however, I'm very, very aware that they don't have the opportunity to do anything else because they're in high security and they're being watched night and day (MHRT5, Lay member).

Another member observed:

the evidence they gave ... was invariably: 'he hasn't been a problem in [name of hospital]'. But what we pointed out of course, was two and a half years in [name of hospital], twenty-four years in maximum security prisons, he hadn't had any opportunity to be dangerous (MHRT7, Lay member).

Like some PB members, MHRT members expressed anxiety about the impact of DSPD services on the wider mental health system. Some members were anxious about how much money was being spent on high security services at the expense of other lower security services (MHRT8, Legal member). This led several members to raise concerns about DSPD services becoming 'silted up'. One psychiatrist observed:

That's one of the concerns of the DSPD. Once it becomes silted up what do you do then? (MHRT11, Medical member).

One legal member highlighted some of the difficulties with progression of patients with personality disorder, and the importance of the patient's reaction and interpretation:

In all these cases there is a huge element of frustration, it seems to me of all the patients [and] necessarily there's a great wariness by those responsible for the detention before any recommendation for either transfer or discharge. And

the caution leads to, it sometimes seems to me, a requirement for treatment and therapies which, I can't say are questionable, but in the way in which they're structured, and the time over which they take, it seems to me have little value and the patients you know, terribly terribly frustrated, year after year they come in front of a tribunal who say 'well you still haven't done the sex offenders course' or whatever it be, and because there are no placements, or sometimes ... it's movement from a ward ... that interrupts the placement ... and then they go to the back of the queue. And it's another year of life. And, and then if they get cross they're put down for being fragile and in a mental state which has potentially a cause for concern. And it can be very difficult for the patient (MHRT9, Legal member).

One Judge made the important observation:

So how do you identify the people who could benefit from this at the beginning of their sentence is a big question I think (MHRT10, Legal member).

How DSPD patients were to move to medium secure services was evidently a concern for some members. One member observed:

so how do you treat those people and how do you ensure ... there is some mechanism for them moving through a treatment programme and, you know, perhaps even going to a less secure environment, not necessarily back into the community, but less secure environments ... so far I haven't been able to see that movement taking place, and I think probably, because it's much more difficult (MHRT2, Lay member).

These observations demonstrate that members were concerned about the lack of resources in lower security, and the willingness of these services to take clients from DSPD services. Similarly to PB members, some MHRT members were worried about the stigma that may follow from being labeled as DSPD. One Judge observed:

there will be areas I guess that are more reluctant to take a former DSPD patient because, maybe because they think they can't do anything for them (MHRT10, Legal member).

The future problem of the rates of re-offending amongst DSPD participants was raised by several members. One psychiatrist observed:

Put them in prison, eighty percent will re-offend, which means twenty percent won't ... so if you send them to a DSPD unit, maybe you'll get that up from twenty percent not offending to say thirty or forty percent but still if you have sixty percent [re-offending] you'd be embarrassed (MHRT12, Medical member).

The issue of recidivism for the success of the DSPD programme was also raised during a joint interview with a psychiatrist and a Judge. The psychiatrist described 'the old way of dealing with antisocial personality disorder' by outlining the system at Grendon Underwood. After the psychiatrist had explained the principles of the democratic therapeutic community, and that prisoners can be voted out by the community for breaching the rules, the conversation continued:

Judge: I can see that such a structure would give hope to people wouldn't it? They would have a real incentive to co-operate?

Psychiatrist: Yeah. The only trouble of course is that it doesn't work.

Judge: In what sense?

Psychiatrist: Well the research ... their own research and independent studies [found] it didn't have any effect on recidivism.

Judge: But that's true of almost every form of criminal punishment isn't it? (MHRT10, Legal member and MHRT11, Medical member interview)<sup>84</sup>.

This brief excerpt from the interview highlights one of the biggest challenges that the DSPD programme is likely to face in the future. Anxieties about the likelihood of re-offending of DSPD participants structures both DSPD unit and MHRT caution in recommending progressive moves for patients, and is a point that will be developed more generally in the final chapter.

## Conclusions

In terms of *outcomes*, the patient sample had a range of experiences when compared to the prisoner sample, with one patient recommended for discharge to the community, others to medium security, one back to the Prison Service, and the majority to remain in DSPD. In terms of the *purposes* of MHRT reviews with DSPD patients these were identified as similar to those involved with PB reviews with DSPD prisoners. These other purposes included: recommending transfers that would enable patients to be closer to their family; questioning the unit about the non-availability of information; suggesting future areas for treatment; and advising that patients be given a clearer idea of progression timetables. Both reviews were identified as sending a number of messages to DSPD patients and prisoners, and to a lesser extent, the DSPD units. In

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<sup>84</sup> In contrast to the psychiatrist's assertion that Grendon does not work, some research has found that it can have a measurable impact on recidivism and reconviction (see Cullen (1994) and Marshall (1997)). For a systematic review regarding the effectiveness of therapeutic communities see Lees, Manning and Rawlings (1999).

comparison to the PB, the MHRT sent clearer recommendations to the DSPD units, reflecting their wider remit.

Generally, MHRT members presented DSPD cases as being no different from other MHRTs with patients detained under the legal category of psychopathic disorder or detained in the high security hospitals. A few members identified that legal status impacted on the work of MHRTs but most were keen to emphasise that the process of MHRT decision-making was the same, irrespective of the section under which the patient was detained. Some members did identify that the section under which the patient is detained may impact on their motivation and engagement with detention in hospital for treatment.

The only participant to find himself recommended for a community discharge was different from the rest of the patient sample in many ways. He was one of the few original Hospital Order patients and the only participant who had not spent time in the Prison Service. At the time of his MHRT in DSPD he was an unrestricted patient. In addition he had spent a long time in DSPD treatment (and in hospital) and had a supportive family on the outside, a resource that many MHRT members pointed out was rare.

The majority of those who were recommended for progression to lower security had a good record of engagement and behaviour whilst in DSPD. This is a positive sign for DSPD patients, in that it demonstrates that it is possible to engage, make progress, and be given a positive recommendation from the MHRT. Of further note is that even if the MHRT felt unable to recommend a progressive transfer, it was still keen to ensure that the treating team was liaising with services in lower security.

In line with previous research, the MHRT most often followed the recommendations of the RMO, highlighting that the RMO and their report play a 'pivotal' role in MHRT decision-making. The MHRT only rejected the advice of the RMO in two cases. In one case, the MHRT went against the RMO in favour of the views of the ASW and forensic psychologist. In the context of the history of psychiatric ambivalence towards those with personality disorder, it could be argued that the opinion of other professionals is given increasing privilege. In another case, the MHRT rejected the RMO's view in favour of the IP's view, but, the patient was still restricted and could be returned to prison. This suggests that the MHRT may be prepared to take risks when DSPD patients can be detained elsewhere. However, where patients were unrestricted and could not be returned to prison, the MHRT preferred the evidence of the RMO and the clinical team over the IP.

While previous research has questioned the extent to which MHRTs are legalistic and properly consider the statutory criteria, in the case of DSPD participants, the MHRT panels made much reference to the statutory criteria, both in their written reasons, and during interview. This may be a result of the uncertainty that surrounds DSPD. Although most patients sought recommendation to medium security, the most common challenge to the statutory criteria was that patients should not be liable to treatment on the basis that treatment was not 'alleviating or preventing deterioration of their condition'. Only one patient was discharged on the basis that he did not meet the criteria to be liable to medical treatment. For all other patients who sought a discharge on the basis that they were not treatable, the MHRT argued that they either had the capacity to engage, and/or had never had any meaningful treatment prior to DSPD, and therefore could not be said to be untreatable. This suggests that MHRT are mindful of risk, and may act more cautiously when faced with the uncertainty that surrounds DSPD.

MHRT members, like PB members, had reservations about DSPD. The biggest anxiety for MHRT was the use of late transfers of determinate sentence prisoners to the mental health system. They were anxious about the ethics of this, and the practical problems that it may generate for the patients and the units. MHRT members were also anxious about the future institutional journeys of DSPD patients. Like PB members, but to a lesser extent, some raised the issue of where DSPD fitted with completion of more traditional programmes like the SOMP. Others observed some of the future dilemmas that may be raised by the re-offending of DSPD participants. Nearly all members raised concerns about the high security services becoming silted up, and the lack of resources in lower security to help patients move on. Others were concerned that DSPD patients may be required to repeat treatment. It is evident that the ability to progress DSPD participants is of crucial importance for the future success of the DSPD units, patients and prisoners. While this will require the DSPD units and external decision-makers to take risks, without adequate and clear progression routes, the potential benefit of DSPD services may never be realised.



## **9. Conclusions: Journeys through managing the unknowable**

*The management of uncertainty is inherently paradoxical, an effort to know the unknowable (Power, 2004:59).*

### **Introduction**

This thesis has explored the institutional journeys and careers of male patients and prisoners prior to, and following, DSPD admission and how placement in a high security DSPD unit may affect the decision-making of PB and MHRT reviews. In doing so, many journeys have been explored including the development of the DSPD Programme and four high security units for men, the journey of the research and researcher, the journeys of DSPD patients and prisoners, and the decision-making journeys of the PB and MHRT with DSPD participants. This concluding chapter draws out a number of policy-related and theoretical conclusions. It concludes that the DSPD units, patients and prisoners are themselves on a journey.

### **1. DSPD is structured by an effort to know more about offenders with personality disorder**

The thesis has argued the DSPD Programme and four high security hospital and prison units for men represent an effort to 'know' more about dangerous offenders with personality disorder. The DSPD programme was set up in advance of, and in search of an evidence base. Historically we have not known how to respond to dangerous offenders with personality disorder; in many respects all we have done is 'contain' them. Yet this has failed to keep a hold of our anxieties about this group, and today,

we feel that we must also 'know' the personality disordered offender in order to guarantee our safety.

While it is positive that investment has been directed towards a previously neglected group, our renewed interest does not correspond to an increasing understanding. The uncertainty that surrounds DSPD disrupts PB and MHRT conceptions of the journeys through the criminal justice and/or mental health system that DSPD participants need to make. It is unclear exactly who DSPD participants have been, who they are, and who they may become. We do not know if DSPD treatment will work to reduce risk and uncertainty. It is also unclear, how, or whether, DSPD patients and prisoners can progress to lower security facilities. What we do know is that previous research suggests that without intervention they are more likely to be reconvicted at a higher and faster rate. It is also probably fair to assume (on the basis of the history of DSPD, *The Sun* newspaper's interest with DSPD services, and recent public, media and political scrutiny of non-DSPD cases like Baby Peter and Dano Sonnex) that one high profile failure has the capacity to undermine the whole programme.

It is important to distinguish between unknown and unknowable uncertainties because the future journeys of the DSPD units, patients and prisoners are both unknown and unknowable. The distinction between unknown and unknowable uncertainties 'depends on the assumption that a subject makes about the availability of information' (Chow and Sarin, 2002:136). Unknown uncertainties are those where the probability is unknown but it is assumed that some have knowledge of them, while unknowable uncertainties are those where no one is believed to know the probability (Chow and Sarin, 2002). This suggests that unknown uncertainties are yet to be determined and can be known, while unknowable uncertainties cannot be known, ever. While DSPD services have been set up to know more about offenders with personality disorder, we cannot know all that we would like to and need to accept that many of the future journeys of the

DSPD units, patients, and prisoners are ultimately unknowable. Some aspects of DSPD that are unknown, can be known, and it is with these uncertainties that we need to focus our attention.

## **2. It is difficult to disentangle the differences between a DSPD patient and a DSPD prisoner, especially prior to admission**

Prior to DSPD admission, patients and prisoners were described by report writers as sharing many similar characteristics and institutional responses. Nearly all had a history of a disruptive childhood and adolescence. Many had a record of prolonged and serious offending, and had spent time in a variety of institutional settings. Most patients and prisoners had adopted a range of institutional responses, and were described as both disruptive and vulnerable. As a consequence the majority had spent time away from 'normal location' in segregation, healthcare, CRC units, therapeutic communities and/or the mental health system.

Despite being well known for their dangerous behaviour and attitudes, DSPD participants were often presented by report writers as something of an unknown quantity. Many had previously failed to complete, or been excluded from, treatment programmes. When treatment had been offered, DSPD patients and prisoners had often been deselected, or if they had completed treatment, doubts about its effectiveness were commonplace. This indicates that services have often not known how to respond to DSPD patients and prisoners, and equally, that DSPD patients and prisoners have not wanted to know or be known.

The most obvious difference between the two samples was their original sentence. The high number of patients in the DSPD hospital units who were serving a determinate prison sentence at the time of their admission, and the high number of life sentence

prisoners in the DSPD prison units demonstrates that DSPD patients had usually been convicted of less serious crimes. It also suggests that admission to a DSPD hospital unit may be as much to do with sentence length and public protection, as it is with the need for treatment. It is important to remember however that the sample considered in this thesis is not necessarily representative of the wider DSPD population, and considers only those prisoners and patients with experience of a PB review or MHRT.

### **3. Following DSPD admission some significant differences in behaviour and engagement can be identified**

Although the institutional responses of DSPD patients and prisoners prior to DSPD admission were presented as fairly similar, following DSPD admission, some significant differences in behaviour and engagement can be identified. Nearly every prisoner was described as having responded positively to their DSPD placement. In contrast, a far more mixed presentation of behaviour and engagement following DSPD admission was reported with DSPD patients.

Improvements following DSPD admission were most often evidenced by a reduction in adjudications and the use of segregation, better relationships with staff and peers, and for some, an increasing motivation to engage with treatment. These improvements were usually attributed to the physical, relational and procedural security of the DSPD units although credit was also given to the treatment programme, the participant's input into the therapy, and realisation on behalf of the patient or prisoner that DSPD may represent the last opportunity to complete offending behaviour work, and make progress towards the community. That the behaviour of prisoners and some patients is presented as having significantly improved following DSPD admission demonstrates that targeted therapeutic programmes for prisoners with chronic institutional careers can be both appropriate and advantageous (Toch and Adams, 2002).

While some patients had responded well to the hospital DSPD units, many had not. Difficult behaviour in the hospital DSPD sites was usually attributed to the late transfer of prisoners to the mental health system or as nothing unusual, and to be expected. That the behaviour of those who had been transferred to a hospital DSPD unit towards the end of their prison sentence was recorded as disruptive, reminds us that co-operation in institutional settings is dependent on perceptions of fairness and legitimate treatment (Liebling, 2007; Sparks et al 1996). These observations demonstrate that DSPD patients and prisoners adopt a range of strategies to manage their detention, and that these may change following DSPD admission. This reminds us that the stage at which an individual is with their sentence may have an important impact on their motivation and engagement with treatment.

**4. The reports submitted to the PB and MHRT present placement in a DSPD unit as appropriate and, in the case of patients, legal under the MHA 1983**

Overall, the reports submitted to the PB and the MHRT present placement in a DSPD unit as appropriate, and in the case of patients, legal under the MHA 1983. This reminds us that the presentation of DSPD patients and prisoners by report writers from the DSPD units also involves characterising the DSPD units. This demonstrates that DSPD staff are under pressure to reassure and generate confidence amongst external decision-makers. Although the outcomes of treatment on a DSPD unit were unknown, report writers presented DSPD treatment as having the potential to turn things around. Treatment was most often presented as comprehensive and as seeking to develop a better knowledge and understanding of the participants.

## **5. PB and MHRT outcomes with DSPD patients and prisoners are different, but the reviews serve many similar purposes**

The outcomes of PB and MHRT reviews with DSPD patients and prisoners differed significantly. No prisoner in the sample was recommended for a progressive move by the PB. In contrast, DSPD patients had a range of experiences with the MHRT, ranging from: an absolute discharge to the community; a recommendation for return to prison; a recommendation for transfer to lower security mental health facilities; and a reclassification of mental disorder. The majority of DSPD patients with experience of a MHRT since DSPD admission received no recommendation from the MHRT. While the *outcomes* of PB and MHRT reviews with DSPD participants differed, the reviews appeared to serve many similar *purposes*.

The PB most often commended DSPD prisoners for their progress so far. For those who had had particularly turbulent prison careers, much credit was given for their new outlook. In some cases it was apparent that the PB review was used to re-iterate that treatment was having a positive effect, even if the prisoner was not in agreement. Occasionally the decision letters offered advice and/or encouraged prisoners to reconsider their approach. While some expressed empathy to the prisoners regarding their situation, they also emphasised that the prisoner was responsible for his reaction to what they ‘understood’ may be a difficult situation. This suggests that PB reviews have the potential to serve a therapeutic function by encouraging motivation and allowing prisoners an opportunity to ‘have their say’. It was rare for PB decision letters to challenge the units, but on a few occasions, the panel expressed concern about the lack of information about risk reduction and the perceived lack of liaison between the DSPD units and the wider Prison Service.

It was evident that MHRT reviews with DSPD patients service a number of similar purposes. These other purposes include: recommending transfers that would enable patients to be closer to their family; questioning the unit about the non-availability of information; suggesting future areas for treatment; and advising that patients be given a clearer idea of progression timetables. These observations highlight the therapeutic potential of MHRTs, and suggest that MHRTs seek to encourage progression through the mental health system, and to commend patients for their progress so far. Although MHRTs were keen to leave the timing of any transfers to clinical judgment, they were also keen to encourage and ensure that a dialogue between the DSPD units and medium secure units emerged. While decision letters did not often challenge the DSPD units, on occasions they responded to the political aspects of DSPD, particularly in regard to 'treatability' and the implications of late transfers to the mental health system for engagement.

These observations demonstrate that a number of messages are negotiated and sent between the units and external decision-makers like the PB and MHRT. PB and MHRT members usually presented their decisions in line with the recommendations of the report writers, suggesting that PB and MHRT reviews may serve an important role in reinforcing the views of the DSPD units. PB and MHRT reviews also offer an opportunity for DSPD participants to have their progress recorded and to enable them to 'have their say'. This indicates that PB and MHRT reviews have attempted to support the journeys of both the DSPD units and the DSPD patients and prisoners.

#### **6. PB and MHRT members hold a range of views and assumptions about the type of people that DSPD has been set up to cater for**

PB and MHRT members held a number of views about DSPD, highlighting that they make assumptions about the type of people that DSPD has been set up to cater for.

The label of DSPD led some to consider a DSPD placement to be 'confirmation of their dangerousness'. Others considered DSPD participants to have the ability to cope with psychological treatment, while some members observed that DSPD participants were 'no different' from other long term prisoners and patients. Most emphasised that while personality disorder was a risk factor it was one of many, and in that respect no more significant. Several observed that DSPD was a positive development because a once neglected group were now able to access treatment services. However there was concern about the potential stigma that could arise from the label of DSPD. Despite these assumptions, PB and MHRT members were keen to assert that the process of decision-making in DSPD reviews was the same as it would be for any other review.

#### **7. The uncertainty that surrounds DSPD disrupts PB and MHRT conceptions of what a normal journey through the criminal justice and/or mental health system looks like**

PB and MHRT members identified that the high security location of DSPD participants was more relevant to their decision-making than the label of DSPD. Members were keen to emphasise the importance of DSPD patients and prisoners moving from high to medium to low levels of security in order for their risk to be 'tested' along the way, suggesting that PB and MHRT members conceive a participant's time in prison, hospital and/or a DSPD unit, in terms of a journey.

The uncertainty that surrounds DSPD disrupts PB and (to a lesser extent) MHRT conceptions of what a normal journey through the criminal justice and mental health system should look like. Although PB and MHRT members reiterated that it was not within their remit to comment on the participant's security categorisation or assess the suitability and/or merits of the treatment programme, the majority expressed doubt and varying degrees of scepticism about whether DSPD treatment was likely to work. PB



members expressed concern about the length, amount and nature of the treatment programmes being offered by DSPD, and uncertainty about whether DSPD treatment was likely to be any better than normal or accredited offending behaviour programmes.

Some members were also anxious about the relationship and impact of DSPD on the wider criminal justice and mental health system. Concerns were raised that DSPD patients and prisoners may be later required to repeat similar offending behaviour programme work. PB members, in particular, were anxious that DSPD participants may become dependent on the units and that there would be considerable problems with trying to reintegrate DSPD prisoners back into 'normal location'. PB and MHRT members were anxious that services in lower security would not want to take DSPD patients and prisoners because of the DSPD label and the short supply of resources in lower security. These concerns led PB and MHRT members to fear that the high security DSPD services were at risk of becoming silted up.

#### **8. PB and MHRT members have some difficulty in making sense of the risk of DSPD participants**

There was a high level of caution amongst DSPD report writers, particularly in the prison units, to claim a reduction in risk. The presence of a number of risk factors was confirmed, but despite improvements in behaviour and engagement, the extent to which treatment was 'working' and risk had been reduced, was largely unknown from the reports. This indicates that many DSPD participants continue to be presented as something of an unknown quantity, and that much caution exists in the management and presentation of DSPD participants to external decision-makers.

Concern was expressed by PB and MHRT members about how they were supposed to make sense of the risk of DSPD participants. PB and MHRT members had concerns

about both actuarial and clinical assessments of risk, and it was evident that they were concerned with both probabilistic and possibilistic aspects of risk. PB and MHRT members identified that risk assessment was more difficult because of the high security conditions of the DSPD units. This was on the basis that DSPD participants were perceived as having had little opportunity to be a risk while resident in DSPD services; as a result, it was difficult to judge if there had been a reduction in risk. Where positive improvements had been made by DSPD patients and prisoners, these were most often attributed to the environment rather than the individual.

That DSPD staff and PB and MHRT members struggle to make sense of the risk of DSPD patients and prisoners is not surprising; they are trying to make judgments and decisions about the unknowable. The DSPD units have emerged within the context of a non-existent evidence base, and predictions about future risk are inherently problematic because 'there are a great many knowable and unknowable factors that influence risk' (Antebi, 2003:16). This reminds us that risk prediction requires 'knowledge of the unknowable, certainty of the uncertain, and completion of the incomplete' (Williams and Arrigo, 2002:23).

## **9. Insufficient attention is paid to how DSPD patients and prisoners will be discharged from the units**

Visible benchmarks, timetables and recognition of progress are important for establishing trust in the potential of the DSPD programme. This thesis has highlighted that the absence of clear benchmarks and progression routes adds to the difficulties experienced by PB and MHRT members in interpreting progress. While the outcomes of treatment on a DSPD unit may be unknowable, key benchmarks along this journey need to be negotiated and made knowable. Without clear progression routes for DSPD participants, decision-makers are likely to be even more anxious about taking risks.

PB and MHRT members were anxious about how DSPD patients and prisoners would be able to progress through the criminal justice and mental health system to lower security facilities. Currently it is unclear how progress in a DSPD unit will be measured and how DSPD patients and prisoners can demonstrate that they have reduced their risk. The discharge pathways out of DSPD services continue to remain uncertain, and it is unclear what levels of support may be available in the community. These are important areas of DSPD that need to be better known.

Duggan (2007:120) reminds us that decisions about the transfer of DSPD participants to lower security conditions will be inevitably problematic because of the 'lack of a proper evidence base that might justify them'. The consequence of this is that 'the system will behave conservatively so that it is likely to detain more than necessary' (Duggan, 2007:120). Paradoxically, this has the potential to generate other risks because it may 'lead to the silting up of the DSPD system which will eventually destroy its capacity to have a positive impact' (Seddon, 2008b:30).

#### **10. The precautionary logic that structures DSPD raises a number of paradoxes with the capacity to undermine DSPD**

The development of DSPD services has been structured by a precautionary logic that seeks to know more about DSPD in order to generate certainty and avoid a worst case scenario. Heberton and Seddon (2009:16) warn us that if we are to adopt the precautionary principle we need to be mindful of the 'paradox that the limitless pursuit of security can end up subverting security and justice in deeply damaging ways'. Others have highlighted that the precautionary logic can lead to 'enormous expenditures on risk assessment and management that ironically reveal the limits of risk-based reasoning and intensify uncertainty' (Ericson, 2007:1).

The precautionary logic that structures DSPD raises a number of paradoxes that have the capacity to undermine DSPD. Introducing new, and as yet unknown services, to respond to the unanswered questions that surround DSPD, does not necessarily generate the reassurance and answers that it was set up to. Instead, the development of DSPD services has introduced new uncertainties and highlighted just how much about DSPD patients and prisoners we do not know.

The increased surveillance, in terms of physical (i.e. CCTV) and psychological (i.e. treatment) mechanisms of knowing DSPD participants, paradoxically makes us more anxious about what would happen if we were to stop watching and talking to DSPD participants. Knowing more is a risky business. The more we know the more anxious we become, not only about what we know but also about what we do not. This highlights how the precautionary logic can generate 'paralysis' (Ericson, 2005:661) because it 'forbids the very steps that it requires' (Sunstein, 2005:4).

Kemshall and Wood (2009) identify that restrictive conditions in the community can exacerbate social isolation and make reintegration more difficult. Paradoxically, this can serve to increase risk. It is evident that similar issues exist within the high security DSPD units. Restrictive security conditions may restrict dangerous behaviour, but as PB and MHRT members have identified, they also restrict decision-making. This in turn makes the progression of DSPD patients and prisoners more difficult. Bottoms and Wiles (1996:35 quoted in Hughes, 1998) remind us that:

improved technical ability to identify and act against offenders will mean that consciously developed policies of reintegration may be necessary if dangerous polarisation and exclusion are not to be the unintended consequences.

Substantial political, financial and professional investment has been made in DSPD. The majority of DSPD patients and prisoners also appear to have invested their trust in the potential of DSPD services. As a consequence, DSPD staff are under pressure to provide answers in a highly uncertain situation, not only to patients and prisoners, but also to PB and MHRT members. For this reason, it is important to recognise that 'risk can only be managed safely if the containment of clinician anxieties is seen as a priority' (Antebi, 2003:8). The uncertainty that surrounds DSPD is likely to encourage defensive and risk-averse decision-making in order to protect individual and organizational image. Labeling a patient as 'high risk' can help 'abrogate responsibility and avoid anxiety' because future enquiry is put to the back of our minds; there is no decision to make (Antebi, 2003:12). While this may protect the reputation of decision-makers, there is a risk that the 'patient is split off as bad, and we may cease the struggle to understand and to help' (Antebi, 2003:12).

This demonstrates that a precautionary logic may paradoxically prevent us from knowing more about DSPD because it generates additional caution amongst DSPD staff and PB and MHRT decision-makers. The 'passive avoidance of risk taking may itself be harmful' (Carson, 2008:143) and sometimes, 'in order to reduce risk, professional agencies need to take risks' (Crasatti, 2007:227). If we want to know (and understand) more about those identified as DSPD then we need to take risks, and accept a degree of uncertainty. The problem with this of course is that 'there are few prizes for taking risks with offenders, only penalties' (Tuddenham, 2000:175 quoted in Padfield, 2007:160).

## **11. We need strategies that tolerate and build on the unknowable, rather than presenting it as resolvable**

Despite there being a 'number of significant issues in "knowing" high risk or dangerous offenders, policy, legislation and practice are all conducted as *if* we can know them' (Kemshall, 2008:13). In response to the criticism that followed the Chief Inspector of Probation's report (HMIP, 2006b) of the release of Anthony Rice from prison, the then Chairman of the PB was quoted as saying 'we will be absolutely sure before we release' (BBC, 2006). While statements like these may temporarily reassure the public, being 'absolutely sure' is not achievable, and may actually serve to heighten public anxieties and dissatisfaction when things do go wrong.

Power (2004:62) argues that if we are determined to act as if we can know the unknowable then we must 'generate legitimacy for the possibility of failure'. The public need to be made aware of the challenges involved with the management of 'dangerous' offenders, rather than being promised certainty about the unknowable. Duggan (2007:119) reminds us that while certain treatment programmes 'are effective in reducing reoffending, they certainly will not eliminate it'. It is important that we are mindful of this when evaluating and interpreting the success of DSPD services. Zero-tolerance towards the reoffending of DSPD patient and prisoners is not achievable because DSPD is likely to have its successes and failures.

One of the challenges for the futures of DSPD is that one high profile failure will be well known and have the potential to undermine the whole programme. In such an event it will probably be forgotten that many positive, but largely unknowable developments are also likely to have taken place. It is unfortunate that 'successful decision outcomes (like successful release to the community) are "invisible", only failure has the potential to come to public attention' (Hawkins, 2003:211).

The future of DSPD services is dependent on generating a set of realistic expectations both within and outside the DSPD units that tolerate what we cannot know, rather than presenting it as something we have the ability to resolve. We can only move towards knowing more about 'what works' with personality disordered offenders, if we are prepared to take risks, embrace (rather than dismiss) uncertainty, and accept that while some uncertainties can be made knowable, others are inherently unknowable.

## **12. The DSPD units, patients and prisoners are themselves on a journey where their futures remain largely unknowable**

This thesis has demonstrated that the DSPD Programme, units, patients and prisoners are themselves on a journey. At this stage their futures are both unknown and unknowable. It is within this uncertain context that not only external decision-makers like PBs and MHRTs must make sense of, and make decisions about DSPD, but also patients, prisoners and staff. While confidence may grow as the DSPD units generate additional knowledge, we will not know all that we would like to, and what we do find out will not necessarily correspond to a better understanding of the problems we wish to resolve. While we need to be cautious, we will not know more if we adopt a completely risk averse approach.

Recognising that many aspects surrounding DSPD are unknowable could be regarded as a dangerous conclusion to explore. After all, being 'unknowable' confirms a status of dangerousness (Pratt, 2000a). While identifying that much surrounding DSPD is unknowable has the potential to lead us down a path where DSPD comes to embody the 'monstrous and the limits of science to know or change people' (Simon, 1998:467), it is important that we remember that 'the future is inherently unknowable' (Janus and Prentky, 2003:1448). Rather than incapacitate us, accepting that much is unknowable could actually make decision-making easier (Chow and Sarin, 2002) and thereby

generate acceptance, innovation and trust. Decision-makers feel more secure when information is unavailable and unknowable to all, and given a choice, prefer to make decisions about unknowable rather than unknown uncertainties (Chow and Sarin, 2002). Accepting the inevitability of unknowable uncertainties may have the 'capacity to make us free' (Bernstein, 1998 in O'Malley, 2004a:1).

The challenge then is for us to identify, accept, and realistically act upon what we know, what we can know, and what we cannot. We need to accept that the futures of DSPD services, patients and prisoners are not certain, and that striving for certainty restricts opportunities for developing new ways of working with offenders with personality disorder. Promises to protect the public from unknowable uncertainties, while understandable, may have the capacity to undermine the whole endeavour, and lead us to fear, rather than accept and build on, the limits of science, and programmes like DSPD, to know people.

While progression routes are currently unknown, they can be made knowable if we are prepared to accept that the outcomes of any progressive moves are largely unknowable. Although progressive moves will involve taking risks, failure to take these risks will only serve to generate other risks, and without adequate progression routes, the potential benefit of DSPD services may never be realised. Delays in progress have implications for the engagement and trust of DSPD patients and prisoners, as well as key decision-makers from within and outside of DSPD services. Generating a set of realistic expectations about DSPD and fostering a dialogue with external decision-makers from the PB, MHRT and key gatekeepers from lower security facilities has the potential to increase trust and confidence in the programme, rather than widening the gap between what is expected and what is possible.



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## **Legislation**

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Criminal Justice Act 1967

Criminal Justice Act 1991

Criminal Justice Act 1993

Criminal Justice Act 2003

Criminal Justice and Immigration Act 2008

Criminal Justice and Public Order Act 1994

Crime (Sentences) Act 1997

Criminal Procedure (Insanity and Unfitness to Plead) Act 1991

Mental Health Act 1959

Mental Health Act 1983

Mental Health Act (Remedial) Order 2001

Mental Health Act 2007

Mental Health (Public Safety and Appeals) (Scotland) Act 1999

National Health Service Act 1977

Parole Board (Transfer of Functions) Order 1998

Powers of the Criminal Courts (Sentencing) Act 2000

Prison Act 1952

## **Case Law**

R v Cannons Park Mental Health Tribunal ex p A [1994] 2 All ER 659 (CA)

R (Brooke) v Parole Board [2007] EWHC 2036 (Admin)

R (Brooke) v Parole Board [2008] EWCA Civ 29

R (Home Secretary) v MHRT [2004] WEHC 1029 (Admin)

R (Wheldon) v Rampton Hospital Authority [2001] EWHC Admin 134

Reid v Secretary of State for Scotland [1999] 1 All ER 481 (PC)

Ruddle v Secretary of State for Scotland [1999] GWD 29-1395

Ezeh and Connors v UK (39665/98; 40086/98) [2002] 35 EHRR 28

X v United Kingdom (7215/75) [1981] ECHR 6

### **Parliamentary debates**

House of Commons Debate (1999) Vol325, Col 601, 15 Feb 1999

House of Commons Debate (2008) Vol480, Col1030W, 14 Oct 2008

### **Guidance and rules**

Home Office (2004) MHRT Guidance

Mental Health Review Tribunal Rules 1983

Mental Health Review Tribunal (Amendment) Rules 1996

Ministry of Justice (2007) MHRT Guidance

Parole Board Rules 2004

### **Prison Service Orders**

PSO 0900 Categorisation and allocation

PSO 2000 Adjudications

PSO 4700 Lifer manual (now called Indeterminate sentence manual)

PSO 6000 Parole, release, and recall

PSO 6010 Generic parole process

### **Other**

Dangerous People with Severe Personality Disorder Bill (2000)

Freedom of Information request to DSPD Programme (2005)

Chromis Theory Manual (2005) (Internal document held at HMP Frankland)

**Key websites**

<http://www.dspdprogramme.gov.uk/>

<http://www.personalitydisorder.org.uk>

<http://www.paroleboard.gov.uk/>

<http://www.mhrt.org.uk/>

<http://www.hmprisonservice.gov.uk/>

<http://www.justice.gov.uk/>

<http://www.dh.gov.uk/en/index.htm>

<http://www.mentalhealthalliance.org.uk/>

<http://www.crimereduction.homeoffice.gov.uk/workingoffenders/workingoffenders1.htm>

## **Appendix A**

### **Abbreviations**

ACR	Automatic Conditional Release
ADAs	Additional Days Awarded
ASBO	Antisocial Behaviour Order
ASW	Approved Social Worker
AUR	Automatic Unconditional Release
CALM	Controlling Anger and Learning to Manage it.
CARATS	Counselling Assessment and Thoroughcare Services
CBT	Cognitive Behavioural Therapy
CCRC	Criminal Cases Review Commission
CDA 1998	Crime and Disorder Act 1998
CDS	Common Data Set
CJA 1967	Criminal Justice Act 1967
CJA 1991	Criminal Justice Act 1991
CJA 2003	Criminal Justice Act 2003
CJCSA 2000	Criminal Justice and Courts Services Act 2000
CPA	Care Programme Approach
CRD	Conditional Release Date
C(S)A 1997	Crime (Sentences) Act 1997
CSAP	Correctional Services Accreditation Panel
CTO	Community Treatment Order
DBT	Dialectical Behavioural Therapy
DCR	Discretionary Conditional Release
DHS	Directorate of High Security
DOH	Department of Health
DLP	Discretionary Lifer Panel of the Parole Board
DSM-IV	Diagnostic & Statistical Manual IV
DSPD	Dangerous and Severe Personality Disorder
ECHR	European Convention on Human Rights
ECtHR	European Court of Human Rights
EDR	Earliest Date of Release
ETS	Enhanced Thinking Skills
HCR-20	Historical – Clinical – Risk. Risk management tool
ICD-10	International Classification of Diseases 10
IDEA	Inclusion for DSPD: Evaluation, Assessment and Treatment study (Oxford University)
IPDE	International Personality Disorder Examination
IPP	Imprisonment for Public Protection
HMIPP	Her Majesty's Inspectorates of Prisons and Probation
HO	Home Office
HPO	Home Probation Officer
HRP	Healthy Relationships Programme
HSF	Healthy Sexual Functioning
LED	License Expiry Date
LSP	Life Sentence Plan
MAPPA	Multi-agency Public Protection Arrangements
MAPPP	Multi-agency Public Protection Panel
MEMOS	Multi-method Evaluation of the Management, Organisation and Staffing study (Imperial College)
MHA 1959	Mental Health Act 1959
MHA 1983	Mental Health Act 1983
MHRT	Mental Health Review Tribunal
MoJ	Ministry of Justice
MSU	Medium Secure Unit
NDPB	Non Departmental Public Body
NHS	National Health Service

NICE	National Institute for Clinical Excellence
NIMHE	National Institute for Mental Health in England
NMHDU	National Mental Health Development Unit
NOMS	National Offender Management Service
NPD	Non Parole Date
OASys	Offender Assessment System
PAR	Parole Assessment Report
PB	Parole Board
PCL-R	Psychopathy Checklist – Revised
PCL-R (SV)	Psychopathy Checklist – Revised (shortened version)
PED	Parole Eligibility Date
PPU	Public Protection Unit (Ministry of Justice)
PSO	Prison Service Order
RM 2000	Risk Matrix 2000
RMA	Risk Management Authority
RMO	Responsible Medical Officer
ROTL	Release on Temporary License
RSHO	Risk of Sexual Harm Orders
RSU	Regional Secure Unit
SARN	Structured Assessment of Risk and Need
SOMP	Sex Offender Management Programme
SOPO	Sex Offender Prevention Order
SOSO	Sex Offender Supervision Order
SOTP	Sex Offender Treatment Programme
SPO	Seconded Probation Officer
SPPU	Sentencing Policy and Penalties Unit
TC	Therapeutic Community
VRS	Violence Risk Scale
VRAG	Violence Risk Assessment Guide



## **Appendix B**

**Patient and prisoner information sheet**

**Patient and prisoner consent sheet**



**UNIVERSITY OF OXFORD**  
DEPARTMENT OF PSYCHIATRY

WARNEFORD HOSPITAL  
OXFORD  
OX3 7JX

Monday, 3<sup>rd</sup> October 2005

**PARTICIPANT INFORMATION SHEET**

**Inclusion for DSPD: Evaluating Assessment and treatment (IDEA)**

You are being invited to take part in a research study. Before you decide it is important to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not to take part.

**1. What is the purpose of this research study?**

The Dangerous and Severe Personality Disorder (DSPD) Programme has recently set up 4 new units. We are a research group from the University of Oxford and the Institute of Psychiatry in London. We are evaluating these units in order to understand how they work and how to improve them. Our evaluation is independent of the Prison Service and the High Secure Hospitals' service. The study will run for three years and those taking part will be interviewed once each year.

**2. Why was I chosen?**

You have been chosen because you have been referred to, or are already in, a DSPD unit. Everyone who is referred to one of the units will be invited to take part.

**3. Do I have to take part?**

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and will have chance to ask any questions you still have. When you are sure you want to take part, we will ask you to sign a Consent Form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

You may decide to take part, not to take part, or pull out once you have started. **None of these decisions will affect things in any way. They will not affect your treatment, your sentence plan, your parole or probationary arrangements, the jobs you are allowed to do, or any aspect of your life on the unit.**

**4. What will happen to me if I take part?**

If you take part, we will ask to see you for an interview **once a year for the next three years** (maybe less depending on when you arrived at the unit). This interview will last for **8 hours**, but in practice we will probably need to spread this time over several consecutive days to fit around your other activities. During the interview, we will ask about your thoughts and feelings and past experiences. We will ask your opinions about the way things work on your unit, the people you are in contact with and the treatments you are receiving. We will also ask you to complete some short computerised tests of memory, decision-making and attention which include some emotional images. All the tasks are quite easy. We may also ask you to take part in an in-depth interview about your views and opinions of the service. Please ask if you would like more details of any of the above tasks. We may wish to tape record parts of

the interview as a check on how they are being conducted. We may also ask to quote you anonymously in our publications as an example of user views. In both cases we will ask your permission at the interview.

We would also like your permission to see your prison and medical records, **including the recorded decisions of any tribunals, parole boards or judicial reviews which you may have been subject to**. This is because gathering data on where you have been before, **how you were referred and admitted**, what treatment you might have had in the past and what tests you might have done before is an important part of evaluating this service.

#### **5. What do I have to do?**

There are no special restrictions or requirements if you take part. We only ask that you answer our questions as honestly as possible.

#### **6. What are the possible disadvantages or risks of taking part?**

We do not expect there will be any disadvantages. Some interview questions may involve discussing your past illnesses, personality difficulties or criminal behaviours. The researchers are trained to ask these questions sensitively. You may feel upset by some of the questions. Please tell us if this happens. You may choose not to answer if you wish.

#### **7. What are the possible benefits of taking part?**

We will pay you a small sum for each interview that you complete with us (remember one interview may be spread over several days). If we ask you for a more in depth interview we will pay you a further small sum. The unit you are on will tell us how much to pay. There are no other direct benefits to you in taking part. But our results will help to shape the future of these units and the way in which they operate. We hope they will lead to better methods of assessment and treatment for people coming to the units.

#### **8. What happens when the research study stops?**

You will continue on your programme of treatment and activities as usual. Nothing will be changed by taking part in this study.

#### **9. What if something goes wrong?**

There is very little that can 'go wrong' in this sort of study. If you have a complaint about the research or the research staff, you should initially raise this with the researchers at your unit and, if not resolved, contact one of the senior team members (see details below). For treatment matters you should ask advice at your unit.

#### **10. Will my taking part in this study be kept confidential?**

All information which is collected about you during the course of the research will be kept strictly confidential. All the data will be stored in locked cabinets according to the Data Protection Act. Any information about you that leaves the unit will have your name removed so that you cannot be recognised from it. The only time when this would not apply is if you tell us that you intend to harm yourself, harm someone else or escape from your unit. In that case we are duty bound to inform staff or other authorities.

This work is entirely independent of the prison and clinical staff at your unit. However there may be occasions where their having access to our data would avoid you having to do the same assessment again. Unit staff may ask you and, if you agree, provide a consent form to sign giving them access to this data. We will not hand over any data to staff without having your explicit written consent.

This work is entirely independent of the DSPD Programme. However it is important to be able to use our results in combination with other studies of this service that may be conducted in future. This will give a better long term picture of how the service works and make it possible to continue evaluating the service. For this reason we would like your permission to make your data available, in totally anonymised form, to the DSPD Programme in the future, if they request it. **Your name would not be passed on and you would not be individually identifiable.**

**11. What will happen to the results of the study?**

Our research is entirely independent of the DSPD Programme organisers. However at the end of the study we will be obliged to give them a report of our results. The report will bring together the results from all those taking part across the four units. No-one will be identified in this report. Eventually we expect to publish articles about our findings, present our results at meetings (including 'service user' group meetings), but you will not be identifiable.

**12. Who is organising and funding the research?**

The research is being funded by the National Health Service's Research & Development Programme on Forensic Mental Health, through the 'DSPD Programme'.

**13. Who has reviewed the research?**

The South East Multi-Centre Research Ethics Committee has reviewed and approved this study (05/MRE01/94).

**Contact for further information**

Local Senior RA	Dr Jenny Yiend	Prof Tom Burns
Site address	Department of Psychiatry	Department of Psychiatry
RA Tel.	Warneford Hospital	Warneford Hospital
	Oxford, OX3 7JX	Oxford, OX3 7JX
	Tel. (01865) 223787	Tel. (01865) 226474

If you take part you will be given a copy of this information sheet and your signed consent form to keep.

**THANK YOU FOR TAKING PART IN THIS RESEARCH**



**UNIVERSITY OF OXFORD**  
DEPARTMENT OF PSYCHIATRY

WARNEFORD HOSPITAL  
OXFORD  
OX3 7JX  
TEL: (01865) 223785  
FAX: (01865) 793101

## PATIENT/PRISONER CONSENT FORM

Title of Project: Inclusion for DSPD: Evaluating Assessment and treatment (IDEA)

Name of Researcher: Professor Tom Burns

Please initial box

1. I confirm that I have read and understand the information sheet dated .....  
(version .....) for the above study and have had the opportunity to ask questions.
2. I understand that my participation is voluntary and that I am free to withdraw at any time,  
without giving any reason, without my medical care or legal rights being affected.
3. I understand that sections of any of my prison and medical records may be looked  
at by responsible individuals from the research team where it is relevant to my taking part  
in the research. I give permission for these individuals to have access to my records.
4. I agree that research staff may see and use test results collected when I arrived.
5. I agree to take part in the above study.
6. I am willing to be contacted at a future date about taking part in further research.  
I understand this does not commit me to taking part again, only being approached.
7. I agree that the data collected during this study can be used in conjunction with  
subsequent evaluations, but only in a strictly anonymised form.
8. I agree that parts of my interviews may be tape recorded with my knowledge and  
direct quotations used anonymously in the presentation of results.

<input type="checkbox"/>
<input type="checkbox"/>
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<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>

\_\_\_\_\_  
Name of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name of Person taking consent  
(if different from researcher)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Researcher

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

## **Appendix C**

**Letters to MHRT members**

**Participant information sheet and consent form**

**MHRT interview schedule**



**K E E L E**  
UNIVERSITY

RESEARCH INSTITUTE OF LAW, POLITICS AND JUSTICE

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**CRIMINOLOGY**

January 2008

Dear Member

**RE: Study of Legal Proceedings for Patients and Prisoners held in the Dangerous Severe Personality Disorder (DSPD) Services**

Please allow me introduce myself - my name is Julie Trebilcock and I am a criminology PhD student from Keele University. I am also a research assistant with Imperial College working on a Ministry of Justice funded project concerned with the organisation and staffing of four Dangerous and Severe Personality Disorder (DSPD) units in England and Wales. The main focus of my work is on the operation of Mental Health Review Tribunal (MHRT) and Parole Board (PB) hearings for patients and prisoners placed in these units.

One of the primary aims of the research is to consider how the legal framework and placement in a DSPD unit may impact on the process and outcome of MHRT and PB hearings. Across the four DSPD sites I have been busy conducting a case note review of the records of consenting patients and prisoners in order to track their legal status, and any changes that may have been made to it during or after placement in a DSPD unit.

The next stage of the research is interested to explore the views and experiences of members involved with MHRTs for patients placed in a DSPD unit. The reason you have been contacted is because you have been identified as a member who has sat on a MHRT panel with a patient who has been placed in a DSPD unit. This patient has given me his consent to review his files and the outcomes of any legal proceedings.

I feel that documenting some of the views of MHRT members' about their experience of hearings with DSPD patients is particularly important for the study, and for this reason, would like to ask you to consider taking part in an interview.

I am very conscious that as a Tribunal member your time is likely to be heavily restricted and in order to minimise disruption I am proposing to conduct interviews over the telephone, although a face-to-face interview can be arranged if you would prefer. Either way, the interview would take no more than half an hour and would be conducted at a time most convenient to you. Please find some additional documentation attached to this letter to explain the focus of the interviews further.

I really do hope that you will feel able to take part in an interview about your experience in this area, and I would like to thank-you in advance for considering this request for an interview. If you would like to take part in the study or have any questions please do not hesitate to contact me.

Yours sincerely

Julie Trebilcock

[j.d.trebilcock@ilpj.keele.ac.uk](mailto:j.d.trebilcock@ilpj.keele.ac.uk)



## Tribunals Service

### Mental Health Review Tribunal

5th Floor, 11 Belgrave Road, Victoria, London, SW1V 1RS  
Tribunals Service - MHRT: DX 153240: Victoria 15

November 2007

Dear Colleague,

**RE: Study of Legal Proceedings for Patients and Prisoners held in the Dangerous Severe Personality Disorder (DSPD) Services.**

Enclosed you will find details about a current study in connection with the decision making of Mental Health Review Tribunals. The research is being conducted by a PhD student from Keele University called Julie Trebilcock in collaboration with Imperial College and the Ministry of Justice. The main focus of the study is to consider the process and outcome of Mental Health Review Tribunals for patients placed in the two Dangerous and Severe Personality Disorder units based at Broadmoor and Rampton Hospital.

We support this research, have met with Julie and are satisfied that the study has all the necessary ethical and security clearances to proceed. The study has been approved by the Home Office Project Quality Assurance Board and the Ministry of Justice Research Unit have issued Julie with a Privileged Access Agreement which permits her to interview Tribunal members. In addition the project has ethical approval from the National Research Ethics Service (NRES) of the NHS and local clearance from West London Mental Health NHS Trust and Nottinghamshire Mental Health NHS Trust.

The reason you have been contacted is because you have been identified as a member with experience of a MHRT with a patient from the DSPD services and Julie is hoping you may feel able to take part in a short telephone interview. Some of you may have sat on more than one relevant hearing, but you will have only been contacted if the patient has given his consent to take part in the study. If you do choose to take part in the study, your views will be anonymised and you be not be identifiable in any publication.

The views and experiences of MHRT members are important to document, especially in regard to new initiatives such as the Dangerous and Severe Personality Disorder programme. However, if you do not wish to take part in the study please advise the researcher or the MHRT Secretariat accordingly.

Yours sincerely

His Honour Judge Phillip Sycamore, MHRT Liaison Judge  
Professor Jeremy Cooper, MHRT Regional Chairman South  
John Wright, MHRT Regional Chairman North





## PARTICIPANT INFORMATION SHEET

### Study of Legal Proceedings for Patients and Prisoners with Dangerous Severe Personality Disorder (DSPD)

**K E E L E**  
UNIVERSITY

Imperial College  
London

#### Who is conducting the research?

This research is being undertaken by an Economic and Social Research Council (ESRC) funded Criminology PhD student called Julie Trebilcock from Keele University. Julie is also working for Imperial College on an honorary basis to help complete a Ministry of Justice funded study interested with the process and outcome of Mental Health Review Tribunals (MHRT) and Parole Board (PB) hearings for patients and prisoners placed in one of four Dangerous and Severe Personality Disorder (DSPD) units.

If you have any questions or comments regarding this research please feel free to contact the researcher by phone (01782 584384), email ([j.d.trebilcock@ilpj.keele.ac.uk](mailto:j.d.trebilcock@ilpj.keele.ac.uk)) or in writing (RI of Law Politics & Justice (Criminology), Keele University, Keele, Staffordshire, ST5 5BG).

#### What is the research about?

The primary interest of the study is with the process and outcome of Mental Health Review Tribunals (MHRT) and Parole Board (PB) hearings for patients and prisoners placed in one of four Dangerous and Severe Personality Disorder (DSPD) units. These units, based within two high security hospitals (Broadmoor and Rampton) and two high security prisons (HMP Whitemoor and HMP Frankland) have been set up by the DSPD Programme (a joint initiative of the Ministry of Justice, Department of Health and HMP Prison Service) to assess and treat the needs of men with severe personality disorder<sup>85</sup>.

The reason you have been contacted is because you have been identified as having experience of a MHRT hearing with a patient placed in a DSPD unit. Should you agree to take part in the study, the interview will be "semi-structured" and will seek to explore several key themes:

- The process and outcomes of MHRT hearings (especially DSPD)
- Impact of the legislative and policy framework on the operation of MHRT hearings
- Aims/objectives of MHRT hearings
- Role of discretion/choice in MHRT hearings
- The role and significance of information for decision making
- The significance of dangerousness and risk for decision making
- The significance of participation with treatment and offender behaviour programmes for decision making
- Participant experiences of DSPD (programme, units, individual cases)

While the researcher is interested in the above themes, attention will also be directed to what you consider to be significant. Essentially, the research is interested to explore what you think is important in this area.

#### How will the interview be conducted?

The interview will take no longer than thirty minutes and will be conducted over the phone unless you would prefer a face to face interview.

The researcher will tape record and transcribe the interview so that she has an accurate account of what has been said, and will ensure that you are not misrepresented during analysis and writing-up stages. A copy of this transcript can be made available to you if you wish.

#### What will happen to the results of the study?

The results of the study will be written up in a PhD thesis and incorporated within an Imperial College report to the DSPD Programme, Ministry of Justice. The results may also be published

<sup>85</sup> More information can be found at <http://www.dspdprogramme.gov.uk>

within a peer reviewed journal. Although the researcher may quote you anonymously as an example of participant views, you will not be identifiable in any publication.

**Who has reviewed the study?**

This study has been reviewed and ethically approved by the Centre for Criminological Research and the Research Ethics Committee for the Faculty of Humanities and Social Sciences, at Keele University. The project has also been approved by the Home Office Project Quality Assurance Board (PQAB) and a Privileged Access Agreement (PAA) has been granted by the Ministry of Justice Research Unit. In addition, the study has also been given ethical approval from two NHS NRES committees, and West London and Nottinghamshire Mental Health Trusts (WLMHT & NMHT). The researcher is happy to provide copies of this documentation on request.

The study has also been reviewed by the Mental Health Review Tribunal Service and Professor Jeremy Cooper, Regional Chairmen for the South. Please find a supporting letter from the Regional Chairmen with this documentation.

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**Participant informed consent**

---

Please only return this form to the researcher if:

- You are happy that you understand the information provided to you about the study
- Any questions or queries have been dealt with sufficiently by the researcher
- You are prepared to give your informed consent to take part in the study

NAME:

ROLE:

DATE:

Please retain a copy for your own records

### **MHRT Interview Schedule**

**(Establish rapport)** My name is Julie Trebilcock and my study is interested to consider the outcome of legal proceedings and the legal status of patients and prisoners held in 4 DSPD units. I am particularly interested to explore how the DSPD programme may have impacted on the work of MHRT and PB. I would like to thank you for the time that you have given up to participate in this interview.

**(Purpose and ethics)** I would like to ask you some questions about your background, your role in the MHRT and about your experience of MHRT with DSPD patients. You will have seen a list of key themes in advance which I will adhere to, but I may ask you to clarify or expand on certain points or issues that you raise. I would also like to ask you some more specific questions about a case study - {Name of patient}. Please note that {Patient's name} has given informed consent for information about his treatment and the outcome of legal proceedings to be collected. The study also has full clearance from NHS research ethics committees, the MoJ/HO and is supported by the MHRT Service / Regional Chairmen.

**(Timeline and data management)** The interview should take about 30 minutes. I will be tape record the interview so that I have an accurate record of what you have said and therefore do not misrepresent anything that you say. I will transcribe all interviews and a copy of this can be made available to you if you wish. All records will be anonymised and you will not be identifiable in any publications.

Is everything I have said so far OK with you? Do you have any questions before we begin?

**1. Please could I ask you to start with a brief outline of the work that you do with the MHRT**

*Probe:*

- *How long member?*
- *What role?*
- *Professional background?*
- *Experience of MHRT?*

**2. Can I now ask you a little more about your experience of MHRT with patients based in the DSPD units at Broadmoor and Rampton?**

*Probe:*

- *Have you had sufficient opportunity to become familiar with the work of the DSPD programme and its four units for men? What information have you been provided with about the programme and its 4 units?*
- *Experience of DSPD hearings. No of cases, Types of patient, Different outcomes*
- *Do you feel there are there any differences between MHRT's involving DSPD patients and other MHRTs? Could placement in a DSPD unit impact upon the decision making of the MHRT? If yes, how? If no, why do you think this is?*

**3. Can I ask you how the presence of a diagnosis of personality disorder may impact on the work of the MHRT?**

*Probe:*

- *In your experience what potential do you feel those with personality disorder have for treatment and changing their offending behaviour?*
- *Does the presence of a personality disorder affect your assessments of risk / dangerousness?*
- *What information about (dangerous and severe) personality disorder has been provided to by the unit?*

**4. How do you utilise reports that make reference to dangerousness, risk and likelihood of reoffending?**

*Probe:*

- *What information about risk assessment and prediction tools have been provided to you by the unit? How helpful have these reports been?*

- How do you feel we can best assess the extent of dangerousness and risk? Why is this?
- Do you feel that placement on a DSPD unit may suggest a positive step towards reducing dangerousness and risk OR
- Do you feel that placement on a DSPD unit acts as confirmation of dangerousness and high risk.

**5. What is the significance of treatment and completion of offending behaviour programmes for MHRT decisions?**

Probe:

- In your experience how well do patients in the DSPD units appear to be engaging with the system? Do you have any sense why patients may or may not engage in the programme?
- In your experience how well do patients in the DSPD units appear to be progressing with the system? Do you have any sense why patients may or may not progress in the programme?
- Based on your experience, what are your thoughts about the treatability of patients held in the DSPD units?
- What has your experience been of DSPD treatment reports? How helpful have these been? What do they suggest about progress? Do you feel sufficiently qualified to fully assess this information?

**6. OK, so we have considered some key factors already. I wonder if you could tell me what other factors you feel are influential in MHRT decisions (discharge, transfer, no change)**

Probe:

- legal status
- index offence
- institutional behaviour
- previous placement in mental health / prison system
- attitude towards offence
- discharge plans / home circumstances / supervision
- victim perspective
- What is the significance of changes in policy and law (ie DSPD / MHA reform) for MHRT decision making?
- How much discretion do you feel the MHRT has with DSPD patients?
- What role do other members bring to the proceedings? (i.e. legal, medical, independent)

**7. Please can we end with a summary of your experience and your thoughts about the DSPD programme**

- How do you feel that placement in a DSPD unit may impact upon the decision making of the MHRT? Are there any differences between MHRTs involving DSPD patients and other MHRTs? If so, how?
- Does placement on a DSPD unit suggest a positive step towards reducing dangerousness and risk, OR does it provide confirmation of dangerousness and high risk? Why might this be the case?
- How do you see the future for DSPD patients who are progressing well? What might the future look like for patients refusing to engage with the service?
- What are your views on the overall merits of the programme?

**DSPD Case study**

I note that you were involved with [name of patient]'s case. Would you be happy to talk me through the main issues before the Tribunal in your view? How was this MHRT conducted? Were there any significant differences between it and other MHRTs? Do you feel that {name of patient} had progressed on the DSPD unit? What do you base this assessment on? What was the panels assessment of the information supplied about {name of patient}'s progress with treatment on the unit? How was this information assessed? What was the significance of the stage of treatment that {name of patient} had reached for your decisions?

*What sense were you able to make in this case of references to dangerousness, and risk? Was there any evidence of change in this case? How did this information impact on your decision making? How does placement in a DSPD unit impact on your assessment in this case?*

**3. Closing**  
**(Summarize)**

**(Maintain Rapport)** Thank-you – that is everything that I would like to ask you. I am very grateful for the time you have found for this interview. Before we end is there anything that you would like to add?

**(Action to be taken)** I would just like to remind you before we finish that I am planning to transcribe all of the interviews over the next 6 months and a copy can be made available to you if you wish?

Also, if you have any questions about the study in the future please do not hesitate to contact me

## **Appendix D**

**Letters to PB members**

**Participant information sheet and consent form**

**PB interview schedule**



**K E E L E**  
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RESEARCH INSTITUTE OF LAW, POLITICS AND JUSTICE

CRIMINOLOGY

January 2008

Dear Member

**RE: Study of Legal Proceedings for Patients and Prisoners held in the Dangerous Severe Personality Disorder (DSPD) Services**

Please allow me introduce myself - my name is Julie Trebilcock and I am a criminology PhD student from Keele University. I am also a research assistant with Imperial College working on a Ministry of Justice funded project concerned with the organisation and staffing of four Dangerous and Severe Personality Disorder (DSPD) units in England and Wales. The main focus of my work is on the operation of Parole Board (PB) and Mental Health Review Tribunal (MHRT) hearings for patients and prisoners held in these units.

One of the primary aims of the research is to consider how the legal framework and placement in a DSPD unit may impact on the process and outcome of MHRT and PB hearings. Across the four DSPD sites I have been busy conducting a case note review of the records of consenting patients and prisoners in order to track their legal status and their experience of PB and MHRT since admission to a DSPD unit.

The next stage of the research is interested to explore the views and experiences of members involved with Parole Board hearings for prisoners placed in a DSPD unit. Documenting some of the views of Parole Board members' about their experience of hearings with DSPD prisoners is particularly important for the study, and for this reason, I would like to ask you to consider taking part in an interview.

Although you have been contacted because you have been identified as a PB member who has experience of Parole Board hearings with prisoners based in the DSPD units, I will not ask you to comment about an individual case and I will not know what previous cases you may have sat on. Instead I would just like to ask you about your general experience of PB panels with prisoners placed in one of the two prison based DSPD units at HMP Whitemoor and HMP Frankland.

I am very conscious that as a Parole Board member your time is likely to be heavily restricted and in order to minimise disruption I am proposing to conduct interviews over the telephone, although a face-to-face interview can be arranged if you would prefer. Either way, the interview will take no more than thirty minutes and will be conducted at a time most convenient to you. Please find some additional information about the focus of the interviews enclosed with this letter.

I really do hope that you will feel able to take part in an interview about your experience in this area, and I would like to thank-you in advance for considering this request for an interview. If you have any questions about the study or would like to take part please do not hesitate to contact me.

Yours sincerely

Julie Trebilcock

[Click and type recipient's address]

XX March 2008

Dear Colleague

**STUDY OF LEGAL PROCEEDINGS FOR DSPD CASES**

As part of a broad and independent research agenda seeking to evaluate services available to prisoners and patients with Dangerous and Severe Personality Disorder (DSPD), the Parole Board has agreed to facilitate access to those members that have had experience of decision-making in DSPD cases.

Our records indicate that you are one of a small group of members that have sat on at least one panel where the subject was a prisoner within a DSPD Unit (HMP Frankland or HMP Whitemoor). I am therefore writing to you to invite you to participate in a study which is looking specifically at how well HM Prisons (and The Dept of Health) provide information that is relevant to the needs of the Parole Board as an independent Court.

I am enclosing further information about the aims of the study as well as what would be expected from you in practical terms. I am assured that the researcher, Julie Trebilcock will work flexibly to arrange telephone interviews at a time that suits you and that interview transcripts will be made available for double-checking to avoid any possible misrepresentation. I understand that there will be no questioning about decision-making with respect to individual cases which would of course be inappropriate.

Participation is of course entirely voluntary. I anticipate this project will ultimately be helpful in developing and improving services for this complex group of prisoners and therefore hope that you will feel able to agree to be interviewed.

I would be grateful if you could confirm whether you are able to participate in the study by contacting Julie Trebilcock directly. Her contact details are on the attached 'Participant Information Sheet'.

Yours sincerely



Christine Glenn  
Chief Executive  
020 7217 0508  
[christine.glenn5@homeoffice.gsi.gov.uk](mailto:christine.glenn5@homeoffice.gsi.gov.uk)





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**Imperial College**  
London

## PARTICIPANT INFORMATION SHEET

### Study of Legal Proceedings for Patients and Prisoners with Dangerous Severe Personality Disorder (DSPD)

#### Who is conducting the research?

This research is being undertaken by an Economic and Social Research Council (ESRC) funded Criminology PhD student called Julie Trebilcock from Keele University. Julie is also working with colleagues from Imperial College and the University of Oxford on an independent programme of research into the work of 4 specialist units that have been established in prison and special hospital settings for men with Dangerous and Severe Personality Disorder (DSPD).

If you have any questions or comments regarding this research please feel free to contact the researcher by phone (01782 733360), email ([j.d.trebilcock@ilpj.keele.ac.uk](mailto:j.d.trebilcock@ilpj.keele.ac.uk)) or in writing (c/o Centre for Criminological Research, Keele University, Keele, Staffordshire, ST5 5BG).

#### What is the research about?

The primary interest of the study is with the operation of Parole Board (PB) and Mental Health Review Tribunals (MHRT) hearings for patients and prisoners placed in one of four Dangerous and Severe Personality Disorder (DSPD) units. These units, based within two high security prisons (HMP Whitemoor and HMP Frankland) and two high security hospitals (Broadmoor and Rampton) have been set up by the DSPD Programme (a joint initiative of the Ministry of Justice, Department of Health and HMP Prison Service) to assess and treat the needs of men with severe personality disorder<sup>86</sup>.

The main focus of the research is on the legal status of patients and prisoners held in the DSPD units and the outcomes of any legal proceedings they may be subject to. I also want to explore how the DSPD programme may have impacted on the work of PB and MHRT. This later objective will be achieved through a series of interviews with PB and MHRT members.

Should you agree to take part in the study, the interview will take no longer than 30 minutes and will be semi structured. Within this time the researcher would like to ask you some questions about your background, your role in the PB and about your experience of PB with DSPD prisoners. The interview will be semi-structured and will be structured around the following key themes:

- The process and outcomes of PB hearings (especially DSPD)
- The role and significance of information supplied by the DSPD unit
- The role and significance of the prisoner's/ patient's diagnosis of personality disorder
- The role and significance of dangerousness and risk assessment
- The role and significance of treatment and offender behaviour programmes
- Engagement of prisoners with DSPD programme / Parole Board
- Progression of prisoners detained in DSPD

There may be points in the interview when the researcher will ask you to clarify or expand on certain points or issues that you raise. This is because the researcher is interested in what you consider to be important within this area of enquiry. At no point in the interview, will you be asked questions about particular cases, but please feel free to illustrate any of your answers by reference to actual cases - so long as these remain anonymous.

#### How will the interview be conducted?

The interview will be conducted over the telephone unless you would prefer a face to face interview. During the interview you do not have to answer any question that you do not want to and you are free to withdraw from the study at any time without having to explain your reason. The interviewer will record and transcribe the interview. This is so she has an accurate account of what has been said, and will ensure that what you say will not be misrepresented during

<sup>86</sup> More information can be found at <http://www.dspdprogramme.gov.uk>

analysis and writing-up stages. All transcripts will be anonymised and no participant will be identified to a 3rd party, or identifiable in any publications arising from this work. Digital copies and/or transcripts of the taped interview are available from the researcher on request.

What will happen to the results of the study?

The results of the study will be written up in a PhD thesis and incorporated within an Imperial College report to the Ministry of Justice. The results may also be published within a peer reviewed journal.

Who has reviewed the study?

This study has been reviewed and ethically approved by the Centre for Criminological Research and the Research Ethics Committee for the Faculty of Humanities and Social Sciences, at Keele University. The project has also been approved by the Home Office Project Quality Assurance Board (PQAB); the Ministry of Justice Research Unit; two NHS NRES committees; West London Mental Health NHS Trust; and Nottinghamshire Healthcare NHS Trust. Copies of this documentation have been made available to the Parole Board, but the researcher is happy to provide individual members with copies of this documentation on request.

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**Participant informed consent**

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Please only return this form to the researcher if:

- You are happy that you understand the information provided to you about the study
- Any questions or queries have been dealt with sufficiently by the researcher
- You are prepared to give your informed consent to take part in the study

NAME:

ROLE:

DATE:

Please retain a copy for your own records

**Parole Board Interview Schedule**

My name is Julie Trebilcock. I am a PhD student from Keele University. I'd like to thank you first for the time that you have given up to participate in this interview.

I'm working with colleagues from Imperial College and the University of Oxford on an independent programme of research into the work of 4 specialist units that have been established in prison and special hospital settings for men with DSPD. My work is concerned with the legal status of patients and prisoners held in these DSPD units and the outcomes of any legal proceedings they may be subject to. Within this I am interested to explore how the DSPD programme may have impacted on the work of PB and MHRT and I am conducting interview with representatives of both.

I would like to ask you some questions about your background, your role in the PB and about your experience of PB with DSPD prisoners. You will have seen a list of key themes in advance which I will adhere to, but I may ask you to clarify or expand on certain points or issues that you raise. I will not ask you any questions about particular cases, but please feel free to illustrate any of your answers by reference to actual cases - so long as these remain anonymous.

The interview should take about 30 minutes. I would like to record the interview so that I have an accurate record of what you have said and therefore do not misrepresent anything that you say. I will transcribe all interviews for analysis and a copy of this can be made available to you if you wish. All transcripts will be anonymised and no-one I interview will be identified to a 3rd party, or identifiable in any publications arising from this work.

Is everything I have said so far OK with you? Do you have any questions before we begin?

**1. Please could I ask you to start with a brief outline of the work that you do with the PB**

Probe:

- How long member?
- Professional background?
- What role?
- Experience of PB?

**2. Can I now ask you a little more about your experience of PB with prisoners based in the DSPD units at HMP Frankland and HMP Whitemoor?**

Probe:

- Have you had sufficient opportunity to become familiar with the work of the DSPD programme and its four units for men?
- Have you received any information about the DSPD programme and the work of the DSPD units?
- I'm interested in your experience of DSPD hearings. No of cases, Types of prisoner, Different outcomes
- Do you feel there are there any differences between PB's involving DSPD prisoners and PB's held for other non-DSPD prisoners with comparable sentences?

**3. Please can I ask you a little more about how you feel a diagnosis of personality disorder may be important for the Parole Board?**

Probe:

- Does the presence of a personality disorder affect your assessments of risk / dangerousness?
- In your experience what potential do you feel those with personality disorder have for treatment and changing their offending behaviour?
- What information about (dangerous and severe) personality disorder has been provided to by the unit?

**4. What information about risk assessment and prediction tools have been provided to you by the unit?**

Probe:

- How helpful do you find these reports?
- How do you utilise reports that make reference to dangerousness, risk and likelihood of reoffending?
- What do you feel the PB members need to make a secure assessment of the extent of dangerousness and risk?
- Do you feel that placement on a DSPD unit may suggest a positive step towards reducing dangerousness and risk OR
- Do you feel that placement on a DSPD unit acts as confirmation of dangerousness and high risk. Why might this be the case?

**5. What is the significance of treatment and completion of offending behaviour programmes for PB decisions?**

Probe:

- What has your experience been of DSPD treatment reports? How helpful have these been? What do they suggest about progress? Do you feel the information is presented in a way that is clear and comprehensible to members of the PB? Do you feel there are any ways in which their presentation could be improved?
- From your experience of PB's with DSPD prisoners have you been able to form a view about how well prisoners appear to be engaging with treatment AND making progressing through treatment?

**6. OK, so we have considered some key factors already. I wonder if you could tell me what other factors you feel are influential in PB decisions (release, recommendation for lesser security, no change)**

Probe:

- legal status
- index offence
- security classification
- previous placement in mental health / prison system
- institutional behaviour
- attitude towards offence
- discharge plans / home circumstances / supervision
- victim perspective

**7. In conclusion, I'd like to ask you for your general thoughts about the DSPD programme**

- How do you see the future for DSPD prisoners who are progressing well?
- What might the future look like for prisoners refusing to engage with the service?
- What are your views on the overall merits of the programme?

**Closing**

Thank-you - that is everything that I would like to ask you. I am very grateful for the time you have found for this interview. Before we end is there anything that you would like to add?

I would just like to remind you before we finish that I am planning to transcribe all of the interviews over the next 6 months and a copy can be made available to you if you wish?

If you have any questions about the study in the future please do not hesitate to contact me.

## **Appendix E**

### **Useful information from DSPD website**

(Available from

[http://www.dspdprogramme.gov.uk/useful\\_information.html](http://www.dspdprogramme.gov.uk/useful_information.html))

### **Hare Psychopathy Checklist Revised (PCL-R)**

### **DSPD pilot clinical models**

(Reproduced with permission of DSPD Programme)

## Useful Information

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Admission to the DSPD Programme is based on three factors; risk of serious harm, personality disorder and there being a functional link between the two. A candidate for the DSPD high secure units can be admitted for treatment if assessment confirms that:

- S/he is more likely than not to commit an offence that might be expected to lead to serious physical or psychological harm from which the victim would find it difficult or impossible to recover; and
- S/he has an identifiable severe disorder of personality (defined later) and
- There is an evidential link between the disorder and the risk of offending.

In practice, this means that a person is likely to be suitable if they are very high risk of harm to others on OASys (Offender Assessment System) and have previously been assessed by a psychologist or psychiatrist as having a severe personality disorder or meet several criteria indicated later. The 'severe' component will be reflected in a high score on the psychopathy checklist (PCL-R) and /or a diagnosis of two or more personality disorders. The units themselves will determine this.

Treatment is complex and requires a demanding programme of therapy to enable a reduction in potential risks the person poses to other people. It is likely to take a minimum of three years so early identification and referral is essential.

### Personality Disorder

Personality disorders are classified using one of two internationally recognised systems: ICD-10 or DSM IV. Diagnosis is based on information held in existing records, clinical interviews and self-report questionnaires. These are not usually applied to young people, as it is believed that personality continues to develop through late teens. Personality disorder is defined as:

**“An enduring pattern of inner experience and behaviour that deviates markedly from the individual’s culture.”**

DSM-IV identifies three cluster classifications:

#### **Cluster ‘A’ – ‘odd’ or ‘eccentric’**

- Paranoid – interpretation of people’s actions as deliberately demeaning or threatening
- Schizoid – indifference to social relationships and restricted range of emotional experience and expression
- Schizotypal – deficit in interpersonal relatedness with peculiarities of ideation, odd beliefs and thinking, unusual appearance and behaviour

#### **Cluster ‘B’ – ‘dramatic’**

- Histrionic – excessive emotion and attention-seeking, suggestibility, and superficiality
- Narcissistic – pervasive grandiosity, lack of empathy, arrogance, and requirement for excessive admiration

- Anti-social – pervasive pattern of disregard for and violation of the rights of others
- Borderline – pervasive instability of mood, interpersonal relationships and self-image associated with marked impulsivity, fear of abandonment, identity disturbance and recurrent suicidal behaviour and/or other self-harm

#### **Cluster ‘C’ – ‘anxious’ or ‘inhibited’**

- Obsessive-compulsive – preoccupation with orderliness, perfectionism and inflexibility that leads to inefficiency
- Avoidant – pervasive social discomfort, fear of negative evaluation and timidity, with feelings of inadequacy in social situations
- Dependant – persistent dependent and submissive behaviour

For a personality disorder to be present, symptoms must be chronic or persistent (continuing for a long time or frequently recurring) and pervasive (affecting numerous areas of their life, for example, social, employment, personal life, etc). They must also cause the individual or those around him or her clinically significant distress or impairment.

The Royal College of Psychiatrists (1999) suggested that ‘severe’ should be defined as “gross societal disturbance” plus “gross severity of personality disorder within the flamboyant group and a personality disorder in at least one other cluster”.

Psychopathy is not, in itself, one of the DSM-IV or ICD-10 classifications. However, high scoring psychopaths present a particularly high risk of serious offending. Hare (1991) describes psychopaths as “grandiose, egocentric, manipulative, dominant, forceful and cold-hearted... they display shallow and labile emotions, are unable to form long-lasting bonds ...and are lacking in empathy, anxiety, and genuine guilt and remorse. Behaviourally, psychopaths are impulsive and sensation seeking, and they readily violate social norms. The most obvious expressions of these predispositions involve criminality, substance misuse and a failure to fulfil social obligations and responsibilities.”

Psychopathy should not be confused with “Psychopathic disorder” as defined within the Mental Health Act 1983 as “...a persistent disorder or disability of mind (whether or not including significant impairment of intelligence) which results in abnormally aggressive or seriously irresponsible conduct.” This is a legal rather than a medical definition, which encompasses a range of personality disorders, including psychopathy. The Mental Health Act 2007 amends the 1983 Act to remove the categorisation of mental disorder. The legal category of psychopathic disorder will have no significance after implementation of the 2007 Act, planned for October 2008. Liability for compulsion under the amended Act will depend on clinical evidence of “mental disorder”, defined as “any disorder or disability of the mind”.

## **Prevalence**

Estimates of the prevalence of personality disorder in community samples vary between 4 and 13%. Almost half of people with a personality disorder will have at least one other. However, it is significantly higher in the Prison population – 73% of male remand, 64% of male sentenced and 50% of female Prisoners. The most common is anti-social personality disorder, 63%, 49% & 31% respectively. For men paranoid is the second most prevalent and for women borderline. A small study which included high

tariff offenders attending a probation centre found that, where personality disorder was diagnosable, the average was four.

Personality disorder is also more prevalent in substance-misusing populations. Estimates vary, however, in drug services approximately a third of clients have a personality disorder, the most common being cluster B. In alcohol services this increases to just over half of clients with cluster C more prevalent. Assessments need to be undertaken with particular care in these settings as the presentation may be masked or affected by the substance misuse.

Given the high prevalence rates it is clear that the Probation and Prison Services have worked with personality disordered offenders for many years. A significant proportion will not require specific interventions beyond Offending Behaviour Programmes. However, for some, referral to more specialist provision should be considered. These include the DSPD programme, therapeutic communities in Prison and the NHS.

Whilst research indicating what might be effective interventions regarding personality disorder and offending is limited, it is unlikely that the focus will be on 'curing' the disorder, rather, finding effective means of managing the effects of the disorder, through targeting offending behaviour, mental health problems and social functioning.

## DSPD Assessment Process

The process is intended to assess whether an individual meets the **entry criteria** and to plan treatment interventions. The criteria for 'severe' Personality Disorder are one of the following. This is assessed using the Psychopathy Checklist – Revised (PCL- R) and a DSM-IV diagnosis through the International Personality Disorder Examination (IPDE):

Entry Criteria	Men	Women
PCL-R score	30 or more	25 or more
PCL-R score	25-29 – and one or more personality disorders (PDs), other than antisocial (ASPD)	18-24 – and two or more PDs other than ASPD
Multiple PDs (DSM-IV)	Two or more	At least three

The criteria for **risk** are based on information gained from the tools outlined below, with the exception of the last two. These are used to form a structured clinical judgement. The table below is intended only to give a brief overview of the tools used in the DSPD assessment process.

Tool	Description	Comments
VRS (Violence-Risk Scale)	Risk assessment in violent offenders	Strong dynamic element supports measurement of change and formulation of treatment plans
STATIC 99	Actuarial tool for measuring risk in sex offenders	
HCR-20 (Historic – Clinical – Risk)	Risk assessment in violent offenders	20 fields combine static and dynamic factors – supports



		the development of risk management plans
VRS-SO (Violence-Risk Scale – sex offender version)	Sex offender version of the VRS	Strong dynamic element supports measurement of change and formulation of treatment plans
Risk Matrix 2000	Risk assessment tool that categories sex offenders from low to very high risk	
PCL-R (Psychopathy Checklist)	Used to measure the presence and level of psychopathy in an individual	Tool also proven effective predictor of violence risk
IPDE	Measures personality disorder using DSM-IV (Diagnostic & Statistical Manual of Mental Disorders) or ICD- 10 (International Statistical Classification of Diseases and Related Health Problems) criteria	Use of this tool is a component part of the structured clinical diagnosis of personality disorder
SCID-1 (Structured Clinical Interview for DSM-IV-TR)	Semi-structured interview used to assist clinicians in the diagnosis of axis 1 clinical disorders	Axis 1 includes all mental health conditions except mental retardation and PD

## **The Hare Psychopathy Checklist Revised (PCL-R)**

- 1 Glibness/superficial charm
- 2 Grandiose sense of self-worth
- 3 Need for stimulation/proneness to boredom
- 4 Pathological lying
- 5 Cunning/manipulative
- 6 Lack of remorse or guilt
- 7 Shallow affect [i.e. superficial experience and expression of emotions]
- 8 Callous/lack of empathy
- 9 Parasitic lifestyle
- 10 Poor behavioural controls
- 11 Promiscuous sexual behaviour
- 12 Early behaviour problems
- 13 Lack of realistic long-term goals
- 14 Impulsivity
- 15 Irresponsibility
- 16 Failure to accept responsibility for own actions
- 17 Many short term marital relationships
- 18 Juvenile delinquency
- 19 Revocation of conditional release
- 20 Criminal versatility

## **DSPD pilot clinical models**

### **HMP Frankland (Westgate Unit)**

The Clinical Framework at Westgate Unit is based upon the integrated model proposed by Livesley (2003). This model suggests that due to their highly complex and individualised needs, working with a personality disordered forensic population does not require a 'one size fits all' approach. As such the Clinical Framework draws upon a number of theoretical models which evidence has shown to be effective at reducing risk related to offending and / or managing traits associated with personality disorder(s). These models include Cognitive Behavioural, Dialectical Behaviour and Psychodynamic. These theoretical frameworks underpin all the clinical work undertaken at Westgate Unit. The Clinical Framework also incorporates the Chromis components of treatment, developed by OBPU specifically for violent offenders "whose level or combination of psychopathic traits disrupts their ability to engage in treatment and pro social change" (Chromis Theory Manual, 2005).

The Clinical Framework reflects the four domains considered relevant to forensic risk assessment – self management, socio affective, distorted attitudes and offence interests (for example Thornton, 2002). To appropriately apply these to the DSPD population, these domains have been adapted and added to (in collaboration with Thornton).

The resultant Clinical Framework adopted at Westgate Unit features 8 domains:

#### **1. Criteria Assessment**

- Comprehensive risk and personality disorder assessment undertaken via the completion of the Minimum Data Set within a four week period.

#### **2. Westgate Individualised Treatment Needs and Progress (WITNAP)**

- WITNAP is a multifaceted intervention aimed at developing an understanding of the link(s) between an individual's risk and personality disorder; identification of specific, individualised treatment needs and the promotion of therapeutic alliances and readiness to change. The Motivation and Engagement component of Chromis is also offered during the WITNAP process.

#### **3. Psycho-education**

- This domain of treatment aims to develop the offender's understanding of the fundamental concepts within DSPD and how they relate to him as an individual.
- Awareness training is provided in risk assessment and personality disorder.
- In addition an introduction to the treatment available at Westgate Unit is delivered to all offenders so that they can begin to recognise common treatment tools used within the treatment programmes and so they can also consider their own treatment needs from the outset.
- Boundary setting skills are also developed during this domain of treatment as it is believed that this is an essential skill which, once developed, may enable offenders to fully engage and benefit from treatment.

#### **4. Self Management Domain**

- This domain focuses upon self-management skills: specifically in relation to his ability to plan, problem-solve and regulate impulses so as to better achieve long term goals.
- A number of programmes are offered as part of this domain including substance misuse and managing anger.
- The Creative Thinking, Handling Conflict and Problem Solving components of Chromis are also offered during this domain.

#### **5. Social and Interpersonal Competencies**

- This domain is concerned with the 'feelings' experienced by the individual, specifically with reference to how an individual relates to others, how he thinks and feels about himself and others and the impact of these on his social skills.
- A number of programmes are offered which are aimed at developing skills in recognising and controlling emotions such as emotion modulation group work and DBT.

- A social skills competencies package, offering modules such as assertiveness and communication is available within this domain.

#### **6. Attitudes and beliefs**

- This domain focuses on the attitudes and beliefs driving the internal (thoughts and feelings) and external (actions) behaviour of the individual.
- Work completed during this domain concentrates on developing the understanding of cognitive distortions, automatic thoughts, core beliefs and schemas held by the individual.

#### **7. Offence interests**

- All treatment completed within the previous domains is offence focused, and targets areas of risk. Within this domain prisoners will begin to examine these risk factors, in relation to his specific offending behaviour
- It is expected that he will build on the work and skills developed during the previous domains in order to consolidate an understanding of his offending behaviour.
- Relapse prevention and skills practice work will also be completed during this domain
- All types of offending, including sexual, violent, arson and domestic violence will be addressed as necessary with each individual.

#### **8. Progression**

- This domain addresses the needs that would obstruct practical progression towards a good life that is offence-free.
- This section incorporates factors that are likely to impact upon the ability to work towards the consolidation and maintenance of relapse prevention skills. Throughout the provision of the Clinical Framework it is imperative to recognise the responsivity needs of a population with varied and significant offence related risk factors combined with personality disorder diagnoses. To this end, a number of imminent Need Interventions are offered in the following areas: Trauma therapy and Self Managing Self Harm. A number of supporting interventions are also used within the framework including LINKS (a service aimed at developing links between individuals on the unit and significant others) and GLAD (a motivational tool that seeks to acknowledge prisoners' positive behaviour and/or thinking styles, in a manner that is meaningful to that individual. This system replaces the traditional Prison Service Incentive and Earned Privileges scheme).

Westgate Unit recognises the importance of delivering effective clinical interventions and as such has developed its own audit process which enables the regular assessment of treatment integrity, management support and other key issues relevant to the provision of high quality clinical care. Clinical Governance procedures also guide clinical practice on Westgate Unit.

To further evidence the work undertaken, Westgate Unit has a research department dedicated to the evaluation of the effectiveness of the services we provide (both regime and clinical).

Chromis is an accredited intervention that aims to reduce violence in offenders whose level or combination of psychopathic traits disrupts their ability to engage in treatment and change. The treatment ethos and model of change on which it is based are distilled through five components; the sequencing of these can vary in terms of the needs of the participant. In addition, Chromis aims to help provide an environment where prisoners can engage constructively with treatment and generalise skill learnt by focussing on staff support and training. A Staff Development Centre and the provision of training on Working With Psychopathic Offenders are run with this purpose. This training also supports staff in safely working with this client group. In terms of the treatment components, the first is the Motivational and Engagement component that has been specifically designed to engage psychopathic prisoners in treatment and other unit activities and to this end is structured yet flexible, and creates a way of working with participants which is likely to fit well with their responsivity needs e.g. proneness to boredom, impulsiveness. Following this are three cognitive skills components. These are:

The Creative Thinking Component which enables participants to understand, develop and generalise a range of creative thinking skills as well as other treatment needs related to violence. It focuses on personal relevance and enables participants to consider the value of thinking creatively when understanding and resolving problems, achieving their goals, grasping

opportunities and reducing some of the boredom and monotony in their life. It also encourages participants to apply the skills and tools to reducing their risk.

The problem solving component provides participants with a range of skills for defining and resolving problems. It also targets a range of needs related to violence with a number of practical applications.

The Handling Conflict Component focuses on enabling participants to understand, avoid and resolve conflict situations pro-socially and develop negotiation skills. It also focuses on personal relevance and the application of the skills to real life situations.

The final Chromis component is the Cognitive Self-Change Component which focuses most directly on thinking and behaviours associated with participants' past violence and risk of future violent and harmful behaviour. The Component aims to enable participants to understand and reduce their risk of future violence and supports them in developing new pro-social lifestyles, which are fulfilling and enable them to live violence free and positive lives. It also provides staff with an indication of where risk has to be externally managed and how this can be achieved. This is particularly important for the Progression and Resettlement phases of Chromis.

## **HMP Whitemoor (The Fens Unit)**

The theoretical basis of the treatment model adopted by The Fens Unit is cognitive interpersonal. Whilst traditional accredited prison treatment courses work well for many offenders, men who reach criteria for treatment within the Dangerous and Severe Personality Disorder Units have either been excluded from those accredited prison programs by virtue of their personality psychopathology or have completed standard offending behaviour programmes and yet are perceived to continue to pose a high risk of re-offence.

One of the criteria for men to be included in the DSPD treatment programme is that their offending behaviour is linked to their personality psychopathology. The patterns of thinking and behaviours that lead to offending have been learnt throughout the lifespan, as a result of interpersonal pain, trauma and distorted and/or damaging attachment relationships. These patterns of thinking and behaviour are coping strategies to manage negative emotional arousal as a result of unmet fundamental need. Because offending behaviours are so inextricably linked to the personality, such behaviours cannot be changed within a discreet programme without treating the personality pathology. Behaviour targeted treatment ostensibly contains, but does not fundamentally change, the likelihood that offending behaviours will be resorted to, in some form, at times of emotional need. Thus to bring about fundamental change we predict and expect that prisoners will experience emotional crises in which previous coping strategies can be replaced.

Personality disorder is a constellation of coping strategies that a person develops as a response to developmental experience. There are manifest dysfunctions of thinking, feeling, behaviour and interpersonal relationships. As the offending is linked to those areas of dysfunction, the programme aims to address the developmental experiences that generate those areas of dysfunction. Thus throughout the programme on The Fens Unit, those aspects of the personality that lead to offending for each individual are assessed and the remedial therapeutic experiences directly address the aetiological personality characteristics that have resulted in the offending behaviours. Consequently work on each prisoner's offending behaviours is individually formulated to include a developmental psychopathology with detailed assessment of factors that will increase and those that will decrease risk. There is an individual assessment of the motivations to offend, at cognitive and affective levels, defining, directly observing, challenging and recording parallel offending behaviours. Those factors that increase risk for that individual become treatment targets and the interventions are intrinsic to every aspect of the programme.

The programme involves the following components:

**Individual Therapy** –(weekly for the duration of treatment 3-5 years) This focuses on the development of an attachment relationship in which the aetiological factors of the personality disorder can be explored and addressed, working therapeutically at the level of affect. This allows the person to experience empathy at the level of affective attunement (feeling with the person) rather than solely verbal cognitions.

**Cognitive Interpersonal Group Therapy** - (weekly for the duration of treatment 3-5 years) This focuses on relationships with others in the group and the facilitators, to develop a sense of connection to one another, to allow self to be challenged regarding their distorted beliefs about themselves and others and to find ways to resolve conflict with others in a healthy manner. This group also focuses on the prisoner's ability to take emotional responsibility for his maladaptive behaviours in both the present and the past and to understand the process of parallel offending and make positive changes to that strategy.

**Schema Focused Therapy** (weekly for 3-5 years) This group aims to enable the prisoner to be able to identify his own patterns of behaving, thinking and feeling (Schema), which contribute to and maintain their maladaptive behaviours; to challenge maladaptive schemas that result in distress and difficulties in life and to change schema driven behaviours, particularly those associated with offending.

**Affect Regulation** (Weekly for 2 years) This group aims at facilitating the prisoner the ability to regulate emotion, to recognise when he is diverting one emotion into another and the role of

emotional dysregulation in offending. It the aims to help prisoners manage affect adaptively, experience and demonstrate empathy at the level of affect It also aimed at facilitating the prisoner to manage affect more adaptively rather than covert all vulnerable emotion to anger and engage in offence related behaviours.

**Offending Behaviour Groups** (weekly for a year to eighteen months) The aims of this group are primarily to enable the prisoners to develop a clear understanding of their offending process, the most likely routes to re-offend and other possible routes to re-offend. To enable them to recognise patterns of parallel offending behaviours, to identify emotional and physical risk factors related to offending and to challenge distorted offence related cognitions and beliefs; to find non-offending ways of meeting needs that the person finds desirable, acceptable and obtainable and to develop coping mechanisms that work fast and effectively. Consequently they will be able to identify and test detailed relapse prevention plans in practice.

**Addictive Behaviour Groups** – Almost all of the prisoners on the unit have used dysfunctional strategies to manage affect that have become addictive. These behaviours may have had a direct effect on their physiological system such as psychotropic substances (e.g. prescribed or illicit drugs), alcohol, nicotine or an indirect effect by behaviours such as violence, self harm, sexual behaviours, gambling, eating (in excess or starving), and theft. Prisoners will be enabled to recognise the role these addicted behaviours have played and find alternative and more personally adaptive strategies.

**Healthy Sexual Functioning** (as appropriate- weekly for approximately 9 months) An adapted version which leaves out the areas covered in the rest of the programme The effectiveness of these interventions are assessed by considering changes in the prisoner's interpersonal behaviours, cognitions, affect processing and regulation and actual and parallel offending behaviours.

### **Rampton Hospital (Peaks Unit)**

As a preamble to providing a summary of the clinical model being implemented at the Peaks, it maybe useful to summarize the clinical profile of patients admitted:

- Significant prevalence of multiple personality disorders, with a particular high frequency of borderline and antisocial personality disorders.
- Significant issues around patients' cognitive processing deficits (ranging from inherent low to borderline IQ, brain insult, unstable patterns of disability and varying learning styles).
- Significant group of poorly motivated, end of sentence prisoners, transferred to the Peaks, who have marked behavioural disturbance, independent of the severity of personality disorder or degree of clinical psychopathy.
- Index and previous offences involving violence, sexual offending, or mixed sexual/violent motives.
- High frequency of substance abuse.

Elements of the clinical model include:

- Provision of a safe environment – the unit has wards organised around varying degrees of structure and supervision. Of particular note is Brecon ward, dealing with the most subversive/behaviourally disruptive patients. In essence, Brecon is organised around behavioural management, high patient to staff contact, limited patient to patient association, and high therapeutic input during association hours.
- The clinical model has as its spine individualised case conceptualisation to attempt to capture the complexity or severity of patients' disorders or risk (which, anecdotally at least, is not captured by psychometric assessments alone). In addition, we are developing a methodology to test hypotheses about the origins of particular behaviours, to reveal patterns/themes so that appropriate clinical interventions can be instituted.
- A major component of early clinical intervention concerns engaging and motivating patients and building therapeutic relationships, particularly important given the nature of transfers from prison to hospital at the end of sentences.
- Treatment of Personality Disorder – two main therapies are in use, namely DBT and CAT. Much emphasis is given to the issue of responsivity (within the risk – needs – responsivity model). Aspects of personality disorder such as fluctuating levels of motivation, difficulties in trusting/forming relationships, variable emotionally dysregulated states, have an impact on engagement in treatment. The resulting liability of the disorder to lapse and relapse are dealt with as responsivity issues.
- Treatment of offending behaviour – violence and sexual offending treatments are being offered or are being planned, as is a substance misuse programme. A major issue in implementing offending behaviour programs of this sort will be how mainstream treatments (for example sex offending and violence interventions) will need to be adapted in order to be suitable for patients with the distinctive characteristics found in the DSPD population.
- A range of other interventions around "life needs" – educational, vocational, leisure and spiritual inputs tailored to individual needs are offered.
- Transitional and rehabilitative interventions are in the planning stages, to allow a smooth transition from the Peaks to levels of care and treatment found in lower security.
- All of the above interventions are planned to occur in a therapeutic milieu in which constructive change is supported and encouraged.



- The Peaks is committed to a close integration between the clinical model outlined above and ongoing research and evaluation – this is central to our business. The effectiveness of all interventions will need to be evaluated routinely as they are implemented.

## **Broadmoor Hospital (Paddock Centre)**

### **DSPD Service Model and Therapeutic Programme**

The CPA process underpins the treatment programmes delivered within the DSPD Directorate. All patients have an individual needs assessment, an individual risk assessment and a named CPA Care Co-ordinator. Each patient has an allocated Therapy Coordinator.

Care and treatment will be dictated by the needs assessment, which is carried out by a multi-disciplinary team with the full involvement of the patient. Each patient will have a clearly written individualised treatment plan signed by the patient's Therapy Co-ordinator, Consultant Forensic Psychiatrist (RMO) and their CPA Care Co-ordinator.

A fundamental principle is the active involvement of the patient in identifying their own needs and treatment goals and reviewing his progress. Treatment plans and CPA forms will be accessible to the patient at all times.

The CPA for each patient will be reviewed every six months and at annual case conferences (refer to Hospital Policy C2).

All professions working within the DSPD Directorate endeavour to pursue the concept of evidence based practice. The teams are committed to providing treatment and interventions based on the foundations of the National Service Framework for Mental Health. Rationale for using treatments will be clearly stated in treatment plans and clinicians are responsible for explaining treatments and interventions to patients, ensuring they are aware of the evidence behind the practice.

The Paddock Centre uses a Cognitive Behavioural Therapy model as its foundation to the wide range of treatments that are provided. Interventions range in their "position" along the Cognitive Behavioural continuum, and some employ a more eclectic approach.

The Paddock Centre is primarily a self contained unit with most activities, treatments and therapies being provided on site but all patients have an individualised care plan drawn from the outcome of risk assessments carried out by a multidisciplinary team.

Ward staff accompany patients to the programmed activities/therapies and support the areas in use.

The primary aim of the treatment programmes is the reduction of risk of sexual and/or violent offending. The treatment focuses on addressing *criminogenic needs*; (those factors that are directly associated with the patient committing crimes) and *therapy inferring behaviours* (factors which do not necessarily present a risk to others, yet "interfere" with a patient's ability to benefit from treatment).

Dynamic risk factors that are identified to be related to risk of re-offending for that individual are specifically targeted for intervention. Equally, protective factors and relative strengths that the patients hold, are consolidated and reinforced.

Progress on each treatment target is regularly monitored by psychometric assessment and behavioural observations; the former incorporating self-report and staff-report.

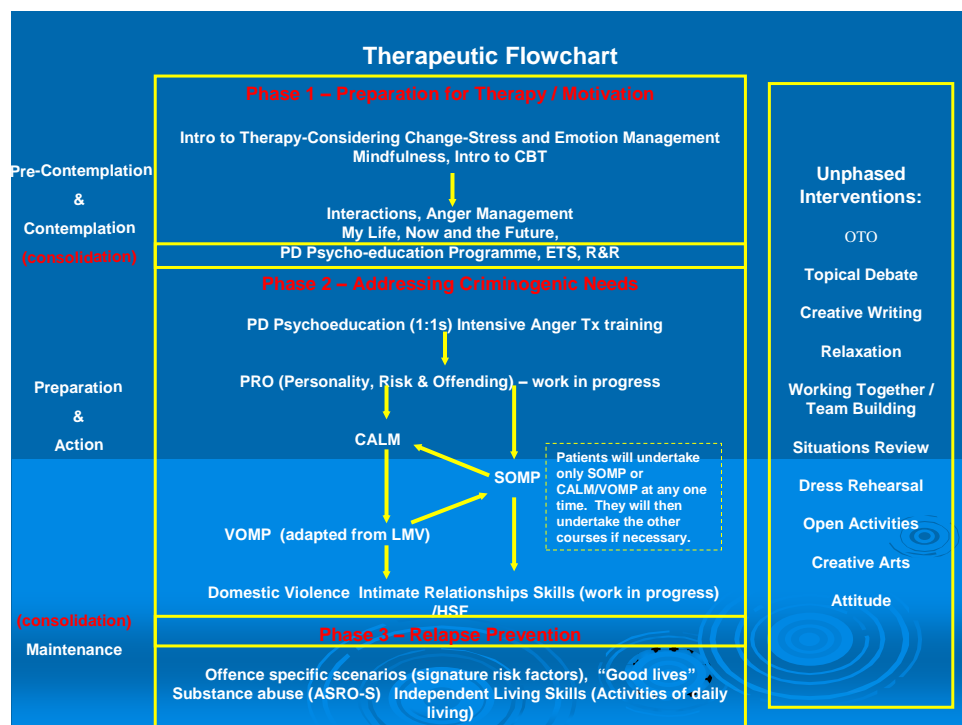
The basis of the programme is primarily a Cognitive Behavioural Therapy model. Meta-analysis of the literature indicates that cognitive behavioural interventions are more effective in reducing recidivism than alternative therapeutic modalities. Furthermore, the inherent structure within CBT offers added benefits within a forensic setting and with a personality disordered client group; both features of which are associated with distorting and minimising responsibility for actions.

The Violence Risk Scale (VRS) or the Sex Offender Version (VRS-SO) are instruments that underpin the delivery of treatment and influences the therapeutic style that staff utilise. In addition to identifying treatment targets it incorporates the stage of change that the patient is

add for each target. A trained member of the multi-disciplinary team completes the VRS/VRS-SO at the patients' first CPA and it is subsequently routinely reviewed. Identified treatment targets from the VRS/VRS-SO are then fed into the Clinical Team meetings and patient Care Plans. More information on this instrument is provided in the accompanying document.

The comprehensive CBT programme is structured to provide a hierarchy of treatment interventions, which are tailored to the patients' needs, abilities and treatment progress. There are three over-arching phases to the overall therapeutic programme each of which corresponds to the pertinent stages of change. For example, the initial phase is a motivational phase that incorporates psychoeducation and the development of self-management skills. This corresponds to a more "contemplative" psychological state; whilst the final phase, draws more upon the "action" and maintenance stage of change by employing relapse prevention interventions. See figure 1, below, for a visual representation of this, whilst Appendix 1 provides further detail.

Figure 1



Patients are expected to engage in a structured day consisting of purposeful activity, including individual psychological therapy sessions, group therapies, working alone on tasks set and other purposeful activities. Patients are encouraged to attend a wide range of psycho-social activities and therapeutic activities that enable general self-development. Such activities may take place at evenings or weekends.

All patients undertake pre and post programme evaluations to monitor progress and plan subsequent treatment targets. They therefore have the opportunity to contribute to the evaluation of therapeutic interventions. They are also required to complete a pre and post programme psychometric measure and knowledge based measure in order to identify the efficacy of the programme.

The service is also in the process of developing a protocol for the pharmaceutical treatment of sex offenders.